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ABSTRACT

These 12 monthly newsletters from 1995 explore the myriad problems encountered by children and adolescents as they grow up. Regular departments in the newsletter issues include "Keep Your Eye On...," which briefly presents results of research into childhood and adolescent problems; "New Research," summarizing research from recent publications and professional conferences; "Guest Commentary," featuring editorials from various professionals working with children and adolescents; book reviews; and client handouts designed for use by practitioners. Major topics featured in the 1995 newsletters include: (1) underage gambling (January); (2) onset of schizophrenia (February); (3) male victims of spouse abuse (March); (4) teen suicide (April); (5) prejudice among children (May); (6) the Oklahoma City bombing and post-traumatic stress disorder among children (June); (7) conflict resolution among toddlers (July); (8) orphanages (August); (9) infant disorders (September); (10) grief counseling (October); (11) sudden infant death syndrome (November); and (12) infant massage (December). A year-end index to the issues in this volume facilitates searching for particular topics. (KDFB)

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The Brown University

Child and Adolescent Behavior Letter

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Monthly reports on the problems of children and adolescents growing up.

Vol. 11, No. 1 January 1995

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Authoritative sources predict major developments in 1995 for children's mental health issues. Watch these pages for continuing coverage and ...

Happy New Year!

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A 14-year-old plays cards for cash: Is it more than fun and games?

By Durand F. Jacobs, PhD

Behavior

One of every two legally underaged adolescents in today's society gambles. Yet there seems to be little public recognition of or concern with teenage gambling. The apparent unwillingness of adults to acknowledge gambling behaviors in their adolescents may reside in their belief that legal sanctions will discourage any "really serious" gambling among those under 18 years of age, so not to worry. Or perhaps it reflects the hesitancy of adult society to face up to its own role in fostering childhood and teenage gambling, since the overwhelming majority of young people who gamble were introduced to this recreational diversion by their parents and relatives.

Can underage gambling simply be dismissed as harmless fun and games? Not any longer.

Adolescents across the United States show an age of onset for gambling long before entering high school. More than a third report their first experience with gambling for money before they were 11 years old, and 70 percent to 88 percent say they first gambled before they were 15.

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When parents default, schools should teach character

By Amitai Etzioni, PhD

Ethics

An estimated half of our families no longer humanize and civilize their children in a satisfactory manner. Thus, our most urgent goal is to figure out how to encourage families to reassume this most elemental responsibility. Until we accomplish this, the task of socializing many of our children will by default fall to educators.

Our culture looks at newborn children through rose-colored glasses. "They're so cute," everyone coos. It is only in looking at them objectively that one realizes that their behavior is rather like that of animals: They take in food, expel waste, and shriek. More importantly, they command no inborn moral or social values, and they do not develop such virtues on their own. These elementary facts are the historical reason that families (nuclear and extended) were entrusted with humanizing and civilizing these little creatures. Unfortunately, in many cases, families do not carry through.

The schools, working closely with communities and parents, must not shrink from this challenge. Private schools should have no undue difficulties putting character education in their curricula, but public schools, still entrusted with 88 percent of America's youngsters, face hurdle after hurdle in attempting to

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This month's client handout: Child, adolescent depression distinct from the adult version

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A self-test for teens

Ask yourself the following questions:

1. Do your friends gamble a lot?
2. Do you gamble at school?
3. Have you ever stayed away from school or work to gamble?
4. Is gambling more important than school or work?
5. Do you often spend your free time involved in gambling activities such as poker, sports betting, dice, etc.?
6. Do you find gambling to be the most exciting activity you do?
7. When you are gambling, do you tend to lose track of time and forget about everything else?
8. Do you often daydream about gambling?
9. Do you feel your friends are envious of you when you win money at gambling and that you get extra attention because of gambling?
10. When you do win, do you want to return to gamble as soon as possible because you believe that you will continue winning?
11. When you lose, do you feel you must bet as soon as possible to win back your losses?
12. Do you often gamble with money you originally intended to use for other things — like lunch, clothing, tapes/CDs, etc.?
13. Do you ever "borrow" money to gamble?
14. Have you ever sold a favorite possession or something very special to you to get money to gamble or pay a gambling debt?
15. Do you try to prevent your family and friends from knowing how much and how often you gamble?
16. Do you ever lie about your gambling? For example, do you ever tell people that you did not gamble or that you won money gambling when in fact you had lost money or possessions?
17. Do you get into arguments with your parents because of gambling or with your friends over a gambling activity?
18. Do you feel depressed or lose sleep or feel guilty because you lost money gambling?
19. Have you ever thought of suicide as a way of solving your problems?
20. Does one or both of your parents do a lot of gambling?

Self-scoring guide:

3-4 yes: Time to wonder if your gambling is getting out of hand.

5-7 yes: You are losing control over your gambling.

More than 7 yes: Seek appropriate help for what is clearly a problem.

Gambling

from page 1

The paradoxical fact is that the overwhelming majority of teenagers who ever gambled were doing so long before they reached the legal age of permission established by society. As is the case with adolescent drinking, society's adults generally appear to forget their role as accessory before the fact, and seem to imply that teenagers invented gambling rather than learned it from them.

A series of independent surveys involving more than 2,700 students from 14 high schools in California, Virginia, New Jersey and Connecticut suggest that, nationally, more than 7 million juveniles are gambling for money with or without adult awareness or approval, and more than 1 million of these are experiencing serious gambling-related problems. Indeed, the prevalence of probable compulsive/pathological gambling among juveniles (4.6 per cent) appears to be more than three times that reported for adult[illegible].4 percent).

Further evidence that underage gamblers follow the model of their parents and other adults is seen in the types of wagering that high school students pursue. These appear to be strikingly similar among teenagers from different states. No systematic data had been available on the types of gambling in which teenagers were involved until Lesieur and Klein, and Jacobs et al. conducted the first studies of this behavior in the mid-1980s.

Favorite games

However, since 1984 it is quite clear that the four favorite games that teenagers play for money are (in rough order of preference): cards with friends and family (about 45 percent); the lottery in the growing number of states where it is available and in neighboring states where it is not (about 43 percent); games of skill, such as golf, bowling and pool played with friends and associates (about 34 percent); and sports betting on football and baseball pools, off-track betting, etc. (about 30 percent), even though most sports betting is illegally pursued with a bookie.

Following in preference behind the top four are playing bingo, shooting dice, and betting at racetracks. In locales easily accessible to casinos, such as in Nevada, the eastern seaboard, and in Indian casinos throughout the middle and far western states, these glitter palaces seem to have an irresistible lure for underage high school students.

Over the past decade, the social zeitgeist in America has greatly increased availability, promotion and glamorization — not to mention the inflated payoffs — associated with commercial gambling. After this decade of unbridled growth, it may well be time for American soci[illegible]to

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re-examine the long-range consequences of its love affair with legalized gambling. Public understanding of gambling problems is where our understanding of alcoholism was some 40 or 50 years ago.

What we can do

Public education is the prime vehicle for generating widespread consciousness of the extent and potential negative consequences of juvenile gambling. It also may motivate involved youth to critically evaluate their own behavior. Greater awareness at governmental levels regarding the large numbers of underage youth who gamble and the potential harm associated with their gambling should lead to firmer enforcement of existing laws that set statutory age limits for gambling and, thereby, reduce the accessibility of this activity to those who are more vulnerable to its impact. The gambling industry itself must generate more vigorous and effective methods for discouraging play by underage youth.

Long past due are periodic state and federally funded social-impact studies to identify the extent to which new and changing forms of legalized gambling contribute to gambling rates and, particularly, to rates of problem gambling among potentially vulnerable groups such as juveniles, women and minorities.

The scientific literature consistently indicates that adolescents are most at risk for developing addictive patterns of behavior, including pathological gambling. The high rates of problem gambling behaviors already documented among high school students clearly indicate the urgent need for early identification and preventive interventions for this high-risk group.

Durand F. Jacobs is a clinical psychologist and a professor of psychiatry at the Loma Linda University School of Medicine. His work describing gambling among teenagers and the vulnerability of children of parents who gamble excessively appear as two chapters in *Compulsive Gambling: Theory, Research and Practice* (Lexington Press, 1989), edited by Howard Shaffer et al.

Keep Your Eye On

... depression in teenage girls.

Adolescent girls suffer more stress and depression than boys, and this trend continues well into adulthood, according to a new study. But a warm, nurturing mother can help buffer the effects of the stressful events that contribute to this depression. The four-year study, conducted by Xiaojia Ge, PhD, and his associates at Iowa State University in Ames and the University of North Carolina at Chapel Hill, evaluated the effects of stressful life events on depressive symptoms in 376 white boys and girls, 9 to 17 years of age, from rural, lower to lower-middle class families. While boys reported slightly more depressed feelings than girls before the age of 13, the trend reversed after that age, with symtoms of depression rising continuously upward for girls until at least age 16, and in many cases into young adulthood. Further, the role of the mother proved considerably important for girls, but not for boys. Girls living in homes where mothers gave them ample support reported fewer depressive symptoms, compared to adolescent girls who did not receive this maternal backing. Supportive mothers showed warmth toward their daughters, listened carefully and made a real effort to talk and socialize with their daughters. (*Developmental Psychology*, 30:4, 1994)

... overweight adolescents.

Among our national health objectives for the year 2000 is that the prevalence of overweight adolescents not exceed 15 percent. The prevalence of overweight for 12- to 19-year-olds was 21 percent during 1988-'91, according to the CDC's third National Health and Nutrition Examination Survey. That represents an increase of 6 percent since the most recent survey. The CDC recommends changes in diet and activity levels and primary prevention of overweight, which has been linked to increased risk for heart disease, diabetes, gallbladder disease and certain cancers in adults. An overweight teen is at greater risk for being overweight as an adult. (*Morbidity and Mortality Weekly Report*, Nov. 11, 1994)

... advertising aimed at children.

Kids Against Junk Food (KAJF), a national group of nutrition-conscious children and teens, awarded a "Lifetime of Irresponsible Achievement Award" to the food companies, advertisers and broadcasters that have promoted unhealthy foods to children. The award was presented last month at the 10th annual Harlan Page Hubbard Awards ceremony in Washington, DC. KAJF was among a group of consumer organizations that gave Hubbard Awards for misleading, unfair or irresponsible advertising. The awards are named after Harlan Page Hubbard, a legendary "snake oil" salesman of the 1890s. At the ceremony, KAJF showed an ad for Kellogg's Frosted Flakes cereal to illustrate the type of junk food ad that bombards kids on Saturday morning. The ad shows a boy playing roller-hockey better and being more popular after eating a breakfast centered around a cereal that's loaded with sugar. KAJF announced three challenges to the award winners. The first challenge goes to advertising companies: to use their creative talent to produce "really cool" ads for healthy foods. The ads should be fun to watch and contain good information. The second challenge goes to food companies — to offer and promote healthier foods for kids. The third challenge goes to TV stations — to do their part and set aside more air time for public service announcements. They could also have kids' TV programs with characters who are healthy eaters. (Kids Against Junk Food is a project of the Center for Science in the Public Interest, 1875 Connecticut Ave., NW, Suite 300, Washington, DC 20009, (202) 332-9110)

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At the Library

It's a sad day when a best friend moves away. Here are books told from the point of view of the child who is left behind. You can find them in most libraries.

Andrew Jessup by Nettie Hilton. Ticknor and Fields, 1993. Andrew Jessup and his friend did everything together: They went to the zoo, shared stamps and washed the dog. Last year, Andrew Jessup lived next door; then he moved away. Yesterday, Madeline Havenblower moved in. She doesn't like stamps, but she can kick a football and help wash the dog. Is it possible to have two best friends? Ages preschool-7. 1-800-225-3362.

I Am Running Away Today by Lisa Desimini. Hyperion Books for Kids, 1992. A cat wants to move away because his house is cold and creaky and the trees are old and broken, but especially because his best friend moved away. When a new friend moves in next door, he changes his mind. His house becomes not too tall nor too small, but cozy and bright, and the trees are just right. He'll stay. Ages preschool-7. 1-800-759-0190

Ira Says Goodbye by Bernard Waber. Houghton Mifflin, 1988. Ira's best friend, Reggie, is moving. Ira is hurt that Reggie seems so happy about the move to Greendale where "everybody smiles all day and has a good time all the time" — that is, until moving day really comes. Ages preschool-8. 1-800-225-3362.

Amber Brown Is Not a Crayon by Paula Danziger. Putnam, 1994. Friends since preschool, third-graders Amber and Justin are a great team. Each knows what the other is thinking. When Justin's house is sold, Amber describes herself as "one very unhappy human being." It's the worst year of her life. Easy reader. Ages 8-9. 1-800-847-5515.

Barbara Goldberg is a contributing editor to *All Kids Considered*, an independent parenting publication.

Speaking of Books

Patterns in the Mind: Language and Human Nature
Ray Jackendoff
New York: Basic Books, 1994
246 pages, $25 (hardback)
1-800-331-3761

Central to this volume is the thesis that language ability is stored in the brain as a set of unconscious patterns, or a "mental grammar." A scholarly work, the book deals extensively with how children learn this grammar.

Mother Father Deaf
Paul Preston
Cambridge, MA: Harvard University Press, 1994
278 pages, $24.95 (hardback)
1-800-448-2242

The title is the expression commonly used among the deaf to refer to hearing children of deaf parents. The author lets a picture of hearing life among deaf parents emerge from personal stories. It is the story of children growing up between two cultures, balancing the worlds of silence and sound as a sense of self and family forms.

ADHD in the Schools: Assessment and Intervention Strategies
George J. DuPaul and Gary Stoner
New York: Guilford Press, 1994
267 pages, $25 (hardback)
1-800-365-7006

For school professionals, this volume addresses school-related problems associated with attention-deficit hyperactive disorders, including underachievement, non-compliance and peer-relationship problems. It provides practical information for educators based on empirical findings. The foreword was written by ADHD expert Russell Barkley.

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Ethics

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breach what in effect amount[s] to value education.

Some argue that the impotence of public schools in addressing moral issues would be dealt with best by instituting a school choice program to enable parents to transfer their children to private schools. But realistically, a national move toward school choice seems unlikely in the near future. The battleground for the character of the new generation will be fought in the public schools. Tough questions immediately fly to mind: Will public schools distribute condoms? Will they teach that Heather has two mommies? Will they condemn abortion? Teaching values in a society embroiled in a passionate argument about how to define its values seems impossible.

Groups with mission

Circumventing the land mines of the culture war is part of the [mis]sion of two new nationwide [group]s mounting major character education drives. Character Counts! was launched with celebrity fanfare (Barbara Jordan and actor Tom Selleck) by the indefatigable Michael Josephson, head of the Los Angeles-based Josephson Institute of Ethics.

It calls for schools to promote six character traits that our society can presumably agree on: trustworthiness, respect, responsibility, fairness, caring and citizenship. The group calls for a public relations campaign to encourage schools to provide youngsters with devices such as flash cards that praise these virtues.

A much richer and more complex agenda is being advanced by a broad coalition of educational groups called the Character Education Partnership (CEP). Led by educator Diane Berreth, retired McDonnell Douglas CEO Sanford

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Child, Adolescent Depression Distinct from the Adult Version

If your child has seemed persistently sad, is uninterested in previously enjoyable activities, and seems at the same time to be doing worse in school, it may be more than "just a phase." About 5 percent of adolescents and 1 to 3 percent of prepubescent children suffer from significant depression.

Depression in children may manifest itself differently than in adults. In addition to the symptoms above, children may complain of headaches, stomach aches or persistent boredom. If you have noticed that your child's eating or sleeping patterns have changed, or that your child's school performance is deteriorating, these may be other signs of depression.

Rather than wait and hope that your child is merely passing through a phase, it's probably best to see a mental health professional. Untreated depression can cause unnecessary suffering or even suicide.

Correct diagnosis

The first step is to get a diagnosis. The same symptoms can be caused by other medical problems, and the mental health professional first needs to rule out such conditions as sleep disorders, substance abuse or the early stages of adolescent schizophrenia.

If the symptoms do indicate depression, there are varying degrees of severity and duration. Your child may suffer from an adjustment disorder with a depressed mood, from dysthymia, or from major depression.

Bipolar disorder (manic-depressive illness) is rare but possible in children and adolescents. Both major depression and bipolar disorder have significant genetic components; if there is a family history of depression or bipolar disorder, they are more likely to surface early in childhood or adolescence.

Treatments

Pharmacologic treatment of adult depression has improved dramatically in the past two decades, and antidepressant drugs have been successful for adults. Unfortunately, antidepressants seem to be less successful for depressed children and adolescents.

This may be because neural pathways are still immature, or

Continued. . .

. . . continued

because chemical balances are different during adolescence. Currently, doctors prescribe antidepressant medications on a case-by-case basis, and some youth do seem to benefit from them.

Active and focused talk therapy seems most successful with depressed children and adolescents. A therapist can address your child's distorted thinking and self-impressions, such as feelings of hopelessness, helplessness, worthlessness, or a combination of perfectionism and low self-esteem.

Because children and adolescents are so dependent on adults for caretaking, the therapist may wish to assess your child's home environment. The therapist may look for abuse, neglect, family conflict or school difficulties. Answering his or her questions honestly will help your child the most.

Severe depression in childhood or adolescence is frequently a chronic and recurrent disorder. As many as 70 percent of school aged children treated for major depression will have a recurrence of depressive symptoms within a five-year period.

However, most depressed children and adolescents respond to various combinations of psychotherapy, family therapy, pharmacologic treatment and environmental improvement. As with most psychiatric disorders, earlier diagnosis and treatment is associated with faster and more complete recovery.

Source: Gregory K. Fritz, M.D., is a professor of psychiatry at Brown University Medical School and director of child and family psychiatry at Rhode Island Hospital, Providence, RI.

The Brown University Child and Adolescent Behavior Letter

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McDonnell, and a former school official from Iowa, John Martin, CEP seeks basic reforms in the curricula of 75 percent of public schools by the end of the century.

CEP stresses that the experiences schools generate are much more character-forming than any ethics lectures delivered by teachers. If school parking lots are danger zones, corridors confrontational, and cafeterias wild, children learn that whoever pushes hardest in their uncivilized worlds carries the day.

On the other hand, if students are kept orderly by patrols of faculty and students, they learn the value of civility.

CEP argues that a constructive school environment can do what certain extracurricular activities (sports, in particular) have long been acknowledged to do: Form character. CEP, hence, strongly urges schools to conduct annual retreats to examine the moral and social lessons generated by the experiences they impart, compared to the values they seek to transmit. If the messages are out of step, they should be realigned.

Traits, not content

Character Counts! and the Character Education Partnership both stress the development of those personality traits that enable people to act civilly and morally instead of focusing on the content of the values that schools should embrace.

First among these traits is the capacity to control one's impulses. The underlying assumption is that aggressive and other antisocial impulses cannot be extinguished; a mature person needs to learn to recognize urges such as murderous anger and acquire ways to curb them or channel them toward socially constructive outlets.

Second, CEP suggests, in an extensive position paper on the matter, that a well-formed person must have what Adam Smith called "sympathy" — roughly, the ability to see oneself in the other person's shoes, what we would refer to today as "empathy." Without this quality, there is little likelihood that children will develop charity, fairness, respect for other people or the virtues present in a moral and civil person.

Shared values

Only when a person possesses these twin capacities is it possible to instill commitments to other values. What those values should be is also less controversial than seems at first glance, for many values are widely shared. No one seriously maintains that lying is morally superior to telling the truth; that rape, theft and killing are morally appropriate, even though there are special circumstances, such as self-defense, where even killing might be cast in a different light.

CEP urges educators to start by imparting these shared values. They then may wish to acknowledge that on other moral issues there are deep differences, and they might urge youngsters to rely on private institutions to learn more about these issues.

Fostering relativism?

Other groups favor teaching values cafeteria style (pro-life beliefs in column A and pro-choice beliefs in column B, for example). I fear that such an approach will foster relativism. These values should be communicated with the full fervor of those who hold them, and it is best achieved outside public schools.

As Charles Haynes of the First Liberty Institute put it: "Students (should) be encouraged to consult their parents and religious leaders for a fuller understanding of how their tradition addresses moral questions." We should not try to pack all values into public schools; schools should be the place for those values we all share and a place to recognize the importance of other values.

In a similar vein, CEP suggests that schools should not ignore the cardinal role of religion in American life. Rather, public schools should teach about religion without lapsing into any particular religious dogma.

Community role

Finally, CEP provides a clear guideline to the challenging question of whether or not schools should abide by the views of the local community it serves or those imposed from the outside? Should schools distribute condoms or teach first-graders about homosexuality if the community is adamantly opposed? CEP's proposed rule of thumb is that the values of the local community should take precedence in all matters except those that violate the society-wide values reflected in the Constitution and its Bill of Rights.

Schools should thus teach the value of free speech and defend it, even if parents favor suppressing viewpoints they abhor (expressed, say, in the student newspaper). On the other hand, schools should refrain from sex education if this is the parents' collective preference. If the parents are divided, parents should be able to excuse their children from such classes. Schools should teach that democracy is the preferred form of government even if most parents in a given neighborhood believe that authoritarian or tribal government is superior, but they should not require children to read Marx if that makes parents see red.

Encouragingly, both Character Counts! and CEP have attracted a great deal of interest in the educational community and a following among parents. Perhaps attention to the moral education of the young is moving up on the public education agenda. It is not coming a moment too soon.

Amitai Etzioni, PhD, is a member of the board of the Character Education Partnership and author of *The Spirit of Community* (Crown, 1993). He is a university professor at George Washington University.

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What's New in Research

This research is summarized from poster sessions presented at the American Academy of Child and Adolescent Psychiatry.

Anger expression related to depression, not family

Depressed children have trouble maintaining cognitive control of their anger and are more likely to deny or suppress it, compared to children with other psychiatric disorders, according to a new study. Eleven children diagnosed with major depressive disorder were compared to 11 non-depressed psychiatric control subjects on two self-report measures, the Pediatric Anger Expression Style and the Family Adaptability and Cohesion Evaluation Scales-III-K. Family cohesion and adaptability had no effect on anger expression, which indicates that it may be more closely related to depression or possibly to other individual differences.

"Characteristics of anger expression in depressed children," J.H. Kashani, MD, et al., University of Missouri-Columbia, 3 Hospital Drive, Columbia, MO 65212.

New scale measures range of self-injuring behavior

A scale that rates the frequency of self-injuring behavior seems to provide clinicians with a reliable, convenient tool that doesn't use the questionable recollection of symptoms by patients or their caregivers. The Timed Self-Injuring Behavior Scale (TSIBS) is a clinician-administered scale that rates the frequency of 16 types of self-injuring behavior during each 10-second interval of a 10-minute observation period. Three raters used the TSIBS to independently rate an autistic patient who exhibited eight types of self-injuring behavior. The raters demonstrated at least 80 percent agreement for the four specific forms of self-injuring behavior the patient frequently exhibited: self-biting, head-punching, head-slapping and hair-pulling. Previous assessment instruments for self-injuring behavior have been criticized for not recording its frequency nor its range.

"Clinical assessment of self-injuring behavior," J.R. Brasic, MD, MPH, et al., New York University School of Medicine, 550 First Ave., New York, NY 10016-6497.

Attention deficits related to status among peers

Children who have poor attention are more likely to have few friends than their classmates, according to a study of 435 second-graders. The students were given a battery of neuropsychological tests of attention functioning. Peer status data were collected from students, and ratings of aggression and shyness/withdrawal were provided by both students and teachers. Attention and peer status were significantly related: Even after the contributions of age, IQ, gender, aggression and shyness/withdrawal were controlled, the attention variables effected peer status. Children with better attention were more accepted by their peers, and children with poorer attention received more nominations of having few friends.

"Attention and peer status in elementary school age students," C.L. Wilcox, MA, et al., Dept. of Psychology, University of Maryland Baltimore County, Baltimore, MD 21228-5398.

Uneven defense mechanisms characterize anorexia

Young people who have anorexia nervosa tend to overuse more mature defense mechanisms than other psychiatrically ill adolescents but immature defenses when compared to normal adolescents. This combination of mature and immature defenses may help explain the strikingly uneven ego functioning seen in patients with anorexia. A total of 37 patients with anorexia were compared to 30 patients with major depressive disorder, 20 with obsessive-compulsive disorder, 53 with borderline personality disorder, 60 with schizophrenia, and 81 healthy control subjects. All of the subjects were assessed with Pfeffer's Ego Defense Scale. The anorectic patients used denial, projection, regression, repression, introjection and intellectualization more than normal subjects. And they used sublimation and intellectualization more than the other psychiatric patients. These findings may lend insight into the psychopathology of anorexia nervosa.

"Defense mechanisms in severe adolescent anorexia nervosa," D. Gothelf and A. Apter, MD, Sackler School of Medicine, Tel Aviv University, Geha Hospital, POB 102, Petah Tikva Israel 49100.

Resources

- A series of new publications are designed to provide guidance to professionals involved in the treatment and prevention of child abuse and neglect. The manuals, co-developed by the National Center on Child Abuse and Neglect, address "Protecting Children in Substance-Abusing Families," "Substitute Care Providers: Helping Abused and Neglected Children" and "Treatment for Abused and Neglected Children: Infancy to Age 18." **Cost:** Single copies free. **Contact:** National Clearinghouse on Child Abuse and Neglect Information, PO Box 1182, Washington, DC 20013-1182, (703) 385-7565 or 1-800-FYI-3366.
- A paper on "A Public Health Approach to the Violence Epidemic in the United States" describes the root causes of violence and offers an alternative, community-based, public health solution to the problem. **Cost:** Free. **Contact:** Contra Costa County Prevention Program, 75 Santa B[illegible]

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from page 6

bara Road, Pleasant Hill, CA 94523, (510) 646-6511.

- A support group for children of lesbians and gays took root when several children at a conference for gay and lesbian parents in 1988 decided to run their own workshops. That grew into a national organization called Children of Lesbians and Gays Everywhere, also known as Gaybies. About 60 similar groups of 5- to 21-year-olds meet across the country for support, advice and camaraderie. **Contact:** Children of Lesbians and Gays Everywhere, PO Box 50360, Washington, DC 20091, (202) 583-8029, Ext. 3.
- A video-based training program is designed to help school personnel and community leaders teach African American youth social skills for dealing with anger. Through a series of three videotapes, students are trained to solve interpersonal conflicts without getting into fights or losing face. Developed by W. Rodney Hammond, PhD, of Wright State University, the tapes show vignettes of dangerous conflict situations and skills that could be used in defusing the situations. **Cost:** $495, free one-day preview. **Contact:** Research Press, Box 3177, Dept. 123, Champaign, IL 61826, phone: (217) 352-3273, fax: (217) 352-1221.
- More than 300 products for people with communication disorders are described in a new catalog. Among the products is a hand-held device that helps people communicate when their speech is unintelligible due to a neurological disorder or a hearing impairment. **Cost:** Free catalog. **Contact:** Crestwood Company, 6625 N. Sidney Place, Dept. 49, Milwaukee, WI 53209, phone: (414) 352-5678; fax: (414) 352-5679.

Coming Up

- Congress has declared the week of Feb. 12 Random Acts of Kindness (RAK) Week, with Feb. 17 designated as RAK Day. Some public schools have already undertaken RAK activities designed to promote character education and citizenship. A random act of kindness could be putting a quarter in a meter so a stranger won't get a parking ticket or driving an elderly neighbor to the store. The phrase was popularized by Anne Herbert in her books *Random Acts of Kindness* and *Kids' Random Acts of Kindness* (Conari Press). **Contact:** Nancy Briggin, RAK Day coordinator, (415) 456-0480.
- The sixth annual National Dropout Prevention conference, "Serious About Success," will be held March 6-9 in San Jose, CA. Topics will include prevention, intervention and recovery; parent involvement; change processes and roles institutions; coordinated and integrated efforts; equity issues; student issues, attitudes and behaviors; and non-traditional programs. **Contact:** NDP Conference, c/o Clair Communications, 1840 41st Ave., #102, Capitola, CA 95010, (408) 457-8722.
- The National School Conference Institute is planning its seventh annual national conference on at-risk students for March 10-13 in Phoenix, AZ. The conference will pay special attention to gangs and substance abuse. Nationally recognized speakers, including Jonathan Kozol, will examine problems associated with the at-risk population, as well as strategies that will lead to success for these students. **Contact:** NSCI, PO Box 35099, Phoenix, AZ 85069, (602) 331-1160.
- The Family Research Consortium, a consortium supported by the National Institute of Mental Health, will sponsor a summer institute for family researchers. The institute will provide a forum for the dissemination, evaluation and discussion of new findings and developments in research design, methods and analysis. A number of junior and senior researchers will be accepted as participants. This year's institute, "Adolescence and Beyond: Family Processes and Development," is scheduled for June 8-11. **Contact:** Donna Fleming, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill, CB# 8180, 105 Smith Level Road, Chapel Hill, NC 27599-8180; phone: (919) 966-3318; fax: (919) 966-7532; e-mail: fleming.fpg@mhs.unc.edu. **Deadline:** March 1.
- Columbia University's Center for Young Children and Families is looking for applicants for its summer fellowship program for doctoral students. "Putting Children First," a fellowship training program in child and family policy with a developmental perspective, offers full-time summer placements for eight weeks in a variety of policy settings in New York City government and nonprofit agencies. Fellows also attend weekly seminars with leading policy scientists and practitioners. Fellows receive a $2,800 stipend and a $250 travel grant. To apply, send a three-page statement describing your interests in policy and research, a current resume, two letters of recommendation and a self-addressed, stamped postcard. **Contact:** Dr. Judith Smith, Center for Young Children and Families, Teachers College, Columbia University, Box 39, 525 W. 120th St., New York, NY 10027, (212) 678-3904. **Deadline:** March 21.

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GUEST COMMENTARY

Biological and non-biological families face the same challenges

By Lita Linzer Schwartz, PhD

Parenting and bonds of attachment are not limited to primary biological relationships. In today's complex world, it behooves *all* parents to rear resilient and responsible children, although the task becomes more difficult as social problems intrude in almost every home.

Helping children to gain resiliency is an important component of child-rearing. The surrogate parents need help to enable them to do this. As several investigators have pointed out, particularly with reference to those rearing abused children in a foster care situation, training is needed to prepare the caretakers to deal with today's complex problems. The Child Welfare League of America has published an interactive series of workbooks called *Homeworks* that can be used by foster and adoptive parents with or without professional help to gain the information and insights needed that will aid them in rearing their non-biological children.

Adoptive parents, who are less likely than foster parents to have had prolonged interaction with social welfare agencies, can also gain insights from meeting with others like themselves who are dealing with adoptive children's questions. Similarly, grandparents raising their grandchildren can benefit from peer-support groups as well as occasional opportunities for relief from child-rearing in order to meet their own needs.

The so-called traditional intact nuclear family is no longer the preeminent setting in which children are raised, and orphanages, where so many thousands of children spent their childhood and adolescence, are rarely found today. Adoption and foster care have long been with us, and even the practice of grandparents rearing grandchildren has a long history. Each of these formats has changed, however, in recent decades as the numbers of children who need rearing by non-biological parents and the problems they may bring with them have multiplied.

What were formerly intrafamilial problems have become social problems, with growing recognition that both temporary and permanent surrogate parents, the preferred alternative to orphanages, are often confronted with stresses for which few of them are prepared, whether these are the physical and emotional outcomes of abuse, the effects of multiple prior placements, the legal (and sometimes political) complications of "open" and transethnic adoption, or the financial burdens on parents with limited incomes.

A few things have not changed: Children need to know that they are welcome and loved family members; they need nurturing; and they need discipline and limit-setting. The goal of raising children to be capable, resilient and responsible adults continues, and there is a need for support groups for many of these parents, as well as respite for those under severe physical or emotional stress.

Raising one's non-biological children has much in common with raising children in the more familiar "natural" family setting, but can also bring many more challenges, as well as multiple gratifications, to those who have chosen this road to parenthood.

Lita Linzer Schwartz is distinguished professor of educational psychology and professor of women's studies at Pennsylvania State University at Ogontz and a diplomate in forensic psychology. This article was excerpted from *The American Journal of Family Therapy* 22:3, 1994.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Vol. 11, No. 2 February 1995

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SPECIAL REPORT

Some at risk for schizophrenia display visible markers in infancy

Research

To pinpoint the onset of schizophrenia we need to understand exactly when behavior becomes different. To this end, some theorists are looking for signs as far back as infancy, even though this disorder doesn't become clinically apparent until late adolescence. The success of these efforts holds promise, not only for developing early screening and intervention strategies, but for discovering the neuropathology of this devastating illness.

"There are some kids who are probably biologically vulnerable to the illness," says Sydney L. Hans, PhD, a developmental psychologist at the University of Chicago. "It's certainly not just environment by itself; it's some kind of interactive phenomenon."

Hans and her colleagues base their research on the diathesis-stress model of schizophrenia: Some individuals start life with a biological vulnerability that, coupled with certain environmental circumstances, leads to full-blown schizophrenia.

Intriguing data are pointing to early indicators of that vulnerability. Hans has been following a group of Israeli children for about 20 years. When they were tested at 4, 8 and 12 months of age, the 19 children of schizophrenic parents scored at least

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Preshoolers hold interesting ideas of how we adults think

By John Flavell, PhD

Development

Young children understand neither the causes nor consequences of thinking, but even 3- and 4-year-olds can distinguish it from other psychological activities. They recognize that thinking is somehow different from seeing, touching, talking and, to some extent, knowing.

Preschoolers also will sometimes infer that another person is thinking, particularly if there is strong behavioral and situational evidence for it. In one of our studies, for example, when the subject child is asked, "While Ellie is deciding, is her mind doing anything?," even 4-year-olds will typically say she is thinking.

Despite these pretty impressive accomplishments, there are a lot of things that preschoolers have yet to learn about thinking and mental attention.

They underestimate the amount of mental activity that goes on in people's heads.

When a child is shown somebody who is sitting facing a blank wall and asked whether the person is having any thoughts and ideas, or whether her mind is empty of thoughts and ideas, only a minority of 3- and 4-year-old children will say there's anything going on in her mind under those conditions.

They'll point to a picture of an empty thought bubble to describe

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This month's client handout: Help children understand aging

Detecting schizophrenia

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10 points lower on the mental measure of the Bayley Scales of Infant Development than both normal children and children of parents with other mental illnesses.

At 8 months, the children of schizophrenic parents also had lower psychomotor scores. At about 10 years of age, the researchers re-examined the youngsters and found that just under half of the children of schizophrenic parents showed signs of neurobehavioral abnormalities in cognitive and motor areas, compared with 24 percent of the other mental illness group and 15 percent of the normal group.

What interests researchers is not just that children of schizophrenic parents show these delays, but that only some of them do, which would be expected in a disorder with a genetic basis.

But what interests Hans and her fellow investigators is not just that children of schizophrenic parents show these delays, but that only *some* of them do, which would be expected in a disorder with a genetic basis. "The hypothesis is — and it remains a hypothesis — that the children who have these neurobehavioral deficits may be the ones who are carrying some kind of genetic vulnerability to the illness," Hans explains.

Maybe the first, and best known, investigator of this possibility was Barbara Fish, MD, who has been called the "grandmother of the field." When Fish, as a young psychiatrist at New York's Bellevue Hospital in 1952, began studying infants of schizophrenic mothers, no one believed that schizophrenia had a genetic basis.

"I was looking for the kinds of things that people started to wake up to 20 years later," says Fish, whose first grant proposal was denied in 1958 because it focused on the genetics of schizophrenia. "In the '50s, child psychiatry was so taken by psychoanalysis. Now the pendulum has swung the other way, and they are captivated by the brain and ignore the environment."

Fish started to notice that the babies of these schizophrenic women were able to remain in quiet states for long periods of time. Normally, a newborn infant will not lie awake in a crib more than about a minute without squirming, crying or falling asleep.

"She is the ultimate clinician; she made very astute, careful observations of the infants," says Hans, who has worked with Fish.

Possible marker

What Fish discovered was a set of subtle delays in behavioral and physical development called *pandysmaturation*, which she proposed as "a 'marker' in infancy for the inherited neurointegrative defect in schizophrenia." Pandysmaturation has three criteria:

- **Transient retardation** of motor and/or visual motor development, followed by an acceleration of development, and a return to more normal levels.
- **Abnormal profile of function** on a single developmental examination, in which earlier simple items are failed while later-occurring, more complex items are passed.
- **Retardation in skeletal growth** that parallels the transient lags and abnormal profile.

"They're things that parents don't necessarily notice; these are subtle delays," Hans says. "It isn't so much the actual size of the children but of the developmental curves of spurts and plateaus."

Clues in home movies

While developmental patterns are one place to hunt for children who will later develop schizophrenia, another investigator is looking directly into their faces. Elaine F. Walker, PhD, and her colleagues at Emory University watch home movies of schizophrenic patients. From these images of childhood birthday parties and family outings, they look for clues in the facial expressions of children who grew up to be schizophrenic as well as their healthy siblings.

'We find essentially further support for the notion that whatever the vulnerability is in schizophrenia, that it is congenital in nature, that it's there at birth.'

Elaine F. Walker, PhD, Emory University

Walker's assistants, who were blind to the identities and diagnoses of the subjects, code the facial affect of the children as either neutral or expressing one of nine emotions: joy, surprise, interest, anger, disgust, contempt, sadness, pain and fear.

They found that the girls who later became schizophrenic had fewer expressions of joy than their healthy sisters. This trend lasted from infancy through adolescence. By contrast, the pre-schizophrenic boys showed a lower proportion of joy expressions during the first four months of life and then a trend toward *more* joy expressions than their healthy brothers in adolescence.

Pre-schizophrenic girls showed less positive emotion than pre-schizophrenic boys. But both boys and girls who later developed schizophrenia showed greater negative emotion than did their same-sex siblings at one or more age periods

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The differences in facial expression between the boys and girls didn't surprise Walker. "We knew that facial emotion is a variable that's highly influenced by sex," she says.

Her findings are borne out by previous evidence that suggests schizophrenia affects men and women differently. Schizophrenic women get sick later, have more affective symptoms, respond better to treatment and function better socially than schizophrenic men.

But the primary premise was her interest in diagnostic group differences, and they bolster other work like hers. "We find essentially further support for the notion that whatever the vulnerability is in schizophrenia, that it is congenital in nature, that it's there at birth," says Walker, who has also studied infant neuromotor differences in preschizophrenic subjects. "By finding that it's influencing facial expression of emotions, we now have evidence that it's influencing behavior in the social realm long before there are any clinical symptoms."

Future implications

All of the research on childhood precursors of schizophrenia add to the knowledge base of a poorly understood disorder, but right now the implications for patients are only potential.

"I would hesitate to use those data at this point for some kind of mass screening procedure for identifying kids who might be schizophrenic. It's tricky, to say the least," says Hans, the University of Chicago psychologist. "You don't want to label kids, particularly if it's not a definite thing, but I think it opens up possibilities for preventive intervention with kids. One of the things that we know about treatment and intervention is that the earlier they start, the more likely they are to be successful."

But the children would be treated for the neurodevelopmental problems, and whether such an intervention would actually prevent the development of schizophrenia later on is doubtful at best.

"I don't think we know enough about the environmental issues that might trigger a breakdown or that might interact with neurobehavioral markers," Hans says. "It's an area of work that we have a very small amount of data on, and aren't getting much more."

Emory's Walker agrees that any kind of screening or preventive program is a long way off; her hope is to better understand the neuropathology of schizophrenia. "You'll come up with a very different set of hypotheses about the neuropathological determinants if you find that there are no premorbid behavioral differences, that they all erupt at the onset of the illness, as compared to finding evidence that there *are* premorbid developmental and behavioral differences," she says. "It's critical to generating hypotheses about the onset of the neuropathology that we understand exactly when behavior becomes different."

NIMH studying childhood-onset schizophrenia

Research on the treatment of childhood-onset schizophrenia is underway at the Child Psychiatry Branch of the National Institute of Mental Health (NIMH). Children and adolescents aged 6 to 18 years old meeting diagnostic criteria for schizophrenia with onset of psychosis before age 12 are being admitted into the Child Psychiatry Unit of the National Institutes of Health Clinical Center. They receive a detailed neurological work-up including, among other things, studies of neurotransmitters hypothesized to be abnormal in schizophrenia. This is a medication trial comparing haloperidol and clozapine.

The 10- to 22- week inpatient program (the length will depend on the child or adolescent's response to medication) will include a medication-fee evaluation phase followed by a double-blind trial. A six-month outpatient phase follows the inpatient program.

The studies will address questions on the relationship of childhood onset schizophrenia to autism spectrum disorders and adult schizophrenia.

As part of the NIMH study, the first controlled trial of clozapine in children is underway, and initial results are promising. Nineteen children between the ages of 11 and 18 years with childhood onset schizophrenia who responded poorly to the usual antipsychotic medications have done well on clozapine with improvements in multiple areas. Clozapine has been tolerated well with no major side effects.

The study will include a total of 35 subjects. To date, 22 patients have been enrolled. Children and adolescents meeting the criteria are being actively recruited nationally. All treatment, travel and lodging is free of charge.

Interested parties are encouraged to contact Marge Lenane, MSW, at (301) 496-7962 or at NIMH, Child Psychiatry Branch, Building 10, Room 6N249, 9000 Rockville Pike, Bethesda, MD, 20892.

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Speaking of Books

Project Head Start: Models and Strategies for the 21st Century
Valora Washington and
Ura Jean Oyemade Bailey
New York: Garland Publishing
197 pages, $32 (hardcover),
$18.95 (paper), 1995
To order call 1-800-627-6273

As Head Start celebrates its 29th anniversary, this book, in one of the author's words, "boldly celebrates" the early childhood program and the services it has provided to 13 million children. The authors provide compelling arguments for the continuing necessity of Head Start, which has been the focus of sharp criticism almost since the beginning. They discuss one of the most important legacies of Head Start: involving the family, particularly fathers. And they counter the image of Head Start as an unstructured "chameleon" with the argument that Head Start's response to changing social conditions, such as the rising rate of substance abuse, is its strength.

Full-Service Schools: A Revolution in Health and Social Services for Children, Youth and Families
Joy D. Dryfoos (foreword by David A. Hamburg)
San Francisco: Jossey-Bass
310 pages, $25 (hardcover), 1994
To order call (415) 433-1767

This book has been awaited by many forward-looking educators and federal agency administrators involved with school development in the United States. Dryfoos addressed the "new morbidities" that are having major deleterious effects on schools and schooling: drugs, violence, stress and sex problems. She calls for an array of integrated support services in schools to help ameliorate the declining welfare of many American families. Like Edward Zigler of Yale, Dryfoos makes a strong argument for schools that function as community centers, and link family systems to child care systems. Dryfoos shows how it can be done, and why it must be done.

Keep Your Eye On

... substance abuse programs for parents.

A Philadelphia-based non-profit organization dedicated to providing treatment and housing for recovering substance abusers has opened its first facility devoted exclusively to fathers and their children and is building another for mothers and their children. The organization, One Day At A Time, admits children to some of the 47 houses it runs throughout Philadelphia, but this is the first time the group will dedicate homes to children living with their parents. The two houses are being funded through a five-year grant from the Department of Housing and Urban Development (HUD) for homeless substance abusers. The homes are based on the therapeutic community model and will be able to serve up to eight parents each. (*Alcoholism and Drug Abuse Weekly*, Jan. 16, 1995)

... dwindling food pantries.

Food pantries may not be able to provide as much to families this winter, as the U.S. Department of Agriculture (USDA) plans to spend just $25 million this fiscal year to supply food banks and other programs for the poor with flour, canned vegetables, fruits and meats. This compares with the $80 million made available under the Emergency Food Assistance Program in 1993. As many as 26 million Americans turn to food pantries, soup kitchens and emergency feeding programs, according to a study by Second Harvest, a nationwide network of food banks. (*CDF Reports*, December 1994)

... high cost of treating wounded youths.

Research by the National Association of Children's Hospitals and Related Institutions found the costs to treat each child struck down by gunfire are enormous. The association examined discharge records from 44 acute care children's hospitals and found that children wounded by gunfire ran up hospital bills averaging $14,434 in 1991. The figure does not include doctor bills or the costs of lifetime rehabilitation for those permanently affected. The organization is now asking all of its 132 member hospitals and pediatric units to track firearms injuries and deaths to heighten public awareness of the problem. The amount spent to treat each child would be enough to pay for a full year of college.

... inadequate juvenile facilities.

Only one quarter or less of the country's juvenile detention and correctional facilities meet recognized standards for bed space, health care, security and suicide control, according to a report prepared for the Department of Justice. The report is based on a study that surveyed 984 confinement facilities holding 65,000 youths in detention centers, training schools, ranches, farms and camps. Crowding was found to be a "pervasive problem." In 1991, nearly half of the confined juveniles were held in facilities where the population exceeded design capacity, while only one fourth were in institutions that met all living space standards. (For a copy of the research summary, *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (NCJ-141873), contact the Juvenile Justice Clearinghouse, Box 6000, Rockville, MD 20850, (800) 638-8736. The full report with the same name (NCJ-145793) is also available.)

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WHAT'S NEW IN RESEARCH

PTSD can occur in infants

Contrary to previous thought, infants and preschoolers exposed to traumatic events can develop post-traumatic stress disorder (PTSD), according to new research by a child and adolescent psychiatrist. The research suggests that PTSD is usually unrecognized in this age group, at least partly because these children are too young to talk about their thoughts and feelings, and the existing diagnostic manuals do not allow for PTSD in very young children.

Children under 4 years of age who develop PTSD express their symptoms in behaviors according to their age level, say researchers. They suggest that sudden behavioral changes in infants and young children may signify child abuse or exposure to other traumatic experiences.

In the study, doctors reviewed 32 cases of children under 4 who experienced traumatic events, ranging from dog bites to physical abuse to witnessing a parent's murder. Using DSM-IV criteria, the reviewers were generally unable to make a definitive diagnosis. Many of the criteria require patients to describe their experiences and feelings verbally.

The researchers revised the diagnostic criteria for PTSD, emphasizing behaviors appropriate to the development level of young children. For example, the revised criteria focused on re-enactment of the traumatic event through repetitive play, rather than verbal reports with recurrent and distressing memories.

"Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood," Michael S. Scheeringa, MD, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(2):191-200. For reprints, write to Scheeringa, Louisiana State University, Department of Psychiatry, 1542 Tulane Ave., New Orleans, LA 70112-2822.

Scale reliably measures children's aggressiveness

A scale that assesses aggressiveness in children seems to be a reliable clinical instrument, according to a new study. The Overt Aggression Scale (OAS) was used to test 36 hospitalized children, ages 5 to 11. Most — 24 — of the children had had at least three aggressive episodes a week, which qualified them for the treatment phase of a carbamazepine trial. On average, the 24 children scored significantly higher on the OAS Aggression Score and Total Aggression Score than the 12 children in the comparison group. The aggressive children were aggressive toward themselves, as well as other people and objects, and they came from more unstable homes than the comparison group. All of the children were assessed with the OAS on a 24-hour basis by the nursing staff. During the day shift, the number of aggressive episodes was higher; during the evening shift, the episode severity was higher. The researchers say their findings indicate the importance of measuring aggression with a symptom-specific and reliable instrument like the OAS.

"The Overt Aggression Scale: A useful instrument for capturing aggressiveness," J.E. Cueva, MD, et al., Dept. of Psychiatry, NYU Medical Center, 550 First Ave., New York, NY 10016. This research is from poster sessions presented at the American Academy of Child and Adolescent Psychiatry's 1994 Conference.

Enuresis is different in children with ADHD

The clinical implications of enuresis may differ for children who also have attention-deficit hyperactivity disorder (ADHD), according to a study of 260 6- to 17-year-old boys. Researchers compared the presence of enuresis in 140 boys with ADHD and 120 without the disorder. While otherwise normal boys with enuresis were at greater risk for learning disability, impaired intellectual functioning and impaired school achievement, this was not the case for enuretic children with ADHD. Enuresis did not increase the risk for psychopathology in either group, nor was it associated with psychosocial adversity nor developmental immaturity. The pattern of findings remained even after the children were categorized by primary vs. secondary and by nocturnal vs. diurnal subtypes of enuresis.

"Clinical correlates of enuresis in ADHD and non-ADHD children," J. Biederman, MD, Massachusetts General Hospital, ACC 725, 15 Parkman St., Boston, MA 02114. This research is from poster sessions presented at the American Academy of Child and Adolescent Psychiatry's 1994 Conference.

Children of addicts may be at risk for mental disorders

A pilot study suggests that children of opioid-dependent parents have high rates of psychopathology and significant dysfunction. Researchers gave the Child Behavior Checklist (CBCL) to 15 girls and 29 boys (average age 10 years) whose parents were being treated at a methadone maintenance clinic. The children's scores were compared to those of two other groups of youngsters: children with attention-deficit hyperactivity disorder (ADHD) plus comorbid psychiatric disorders, and medically referred children without ADHD. The children of addicted parents had significantly worse competency scores and higher scores on both internalizing and externalizing subscales of the CBCL compared to controls but not compared to the comorbid ADHD children. More than half of the children of addicted parents showed signs of significant psychopathology, with one-third of these children with possible conduct disorders.

"A pilot study of behavioral and emotional disturbances in the children of opioid dependent parents," T. Wilens, MD, et al., Pediatric Psychopharmacology Unit, Massachusetts General Hospital and Harvard Medical School. This research is from poster sessions presented at the American Academy of Child and Adolescent Psychiatry's 1994 Conference.

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Thinking

from page 1

what's going on in the person's mind.

When asked whether a person who tries really hard could stop having any thoughts and ideas in his mind of any kind for three minutes, little children say yes and older children say no. Older children recognize that even if you want to, you can't rid your mind completely of ideation. Ideation just happens.

We've shown in several experiments that little children tend to go with appearances, and tend to assume that because there's no evidence, such as a person looking thoughtful or being given a task, that the person isn't thinking.

Even when we use the Piagetian ploy of presenting the child with two different, fully explicit options, older children regularly say that something is going on in the person's mind, and younger children quite commonly — about 60 percent of the time — will tend to say that nothing's going on.

Children may not assume that anything is going on in the other person's mind, even if the person is known to be engaged in a cognitive task.

When one of the experimenters was reading a book or listening to earphones, the children were no more likely to attribute mental activity to her than when she was just sitting there facing the wall.

Even when they say that the person is thinking, children tend to be poor at inferring what the person might be thinking of, even when the evidence is very strong.

We have shown children a pretty flower and then a filthy T-shirt. One of the experimenters asks the other, "How did all that dirt get on the T-shirt?" The other experimenter says, "That's a hard one. Give me a minute," and she turns away as if to rack her brain for the answer.

At that point, we ask the child, "Is she thinking about anything at all?" And quite often, they'll say yes under those circumstances. But if you ask, "What's she thinking about? Is she thinking about the flower, or is she thinking about the T-shirt?," they would divide 50-50.

If they say, correctly, the T-shirt, we ask, "Is she also at the same time thinking about the flower?" Often, they'll say, "Yes, she's thinking about that too."

Children tend to have a poor understanding of attentional focus and limits.

They don't seem to be very good at understanding that when you attend to some things, you ipso facto don't attend to other things.

For example, we asked 4- and 5-year-olds, "If you're thinking with your mind for a teeny-tiny amount of time, would you be having a thought like this" — they're shown a thought bubble with one asterisk in it — "or would you have a whole lot of thoughts, like this" — a thought bubble with six asterisks. The 5-year-olds are beginning to catch on; 85 or 90 percent say you'd only think one thing at a time, you wouldn't be thinking about a whole bunch of things at the very same tiny moment.

Little children are not very good at reporting their own mental activity.

In one experiment, we tell the child we're going to ring a bell in a few seconds, and ring the bell. We do this twice, but the third time, after telling the child we'll be ringing the bell in a few seconds, we don't do it. We then ask the child if anything is going on in his or her mind. They commonly say no. Only about 35 percent of a group of 5-year-olds said that they were thinking about anything.

In most of our experiments, we actually model the answers. We get one of the experimenters to play the role of the subject and answer correctly and then give them a trial, so it's not that they don't have any idea what a good answer might look like. Even when we vary the instructions, provide pre-testing and pre-training and modeling and other sorts of clues, nonetheless, they're not really very good at it.

Children have difficulty identifying their mental processes.

In our most recent study, we asked children to think to themselves what their name sounds like. When asked how they did it — if they said their name inside their head or saw a picture of their name inside their head — little children didn't know. While older subjects quickly realize that this is a verbal event, toddlers don't seem to be able to read into their own recent processes, even in the case where we're quite sure we know what they did. They are better at explaining the opposite scenario, when engaged in a task that requires visual imagery.

It looks as if young children have a different conception of thinking than do adults. The adult understands that people perceive objects and events, and that there are other kinds of mental states that stimulate thoughts and feelings. When you have a thought, that triggers another thought, which may or may not lead to some kind of overt behavior.

But for young children, thoughts are rather mysterious things that just pop into their heads, to the extent that they ever think about them at all, and they don't know from whence they come. They don't have any clear notion that there are cause-and-effect sequences involving thinking.

Young children understand neither the causal antecedents nor the consequences of thinking. That is one of the things that is going to be examined in the theory of mind development over the next few years.

John Flavell is a professor of psychology at Stanford University. This article was adapted from a speech he gave at the American Psychological Association's annual convention in August 1994.

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Help Children Understand Aging

As people age, they often change in ways that can be confusing and upsetting to children. Before taking your children to visit an elderly relative, you should talk with them about what aging means.

Discuss how people's bodies change when aging and how this process affects the ways people interact. As Grandma grows older, for example, she can't see or hear as well. People first lose high-frequency hearing; because children's voices are high, they are especially difficult to hear.

Explain that it may be necessary to talk more slowly, taking turns so everyone is not talking at once. You may say, "if you stand in front of Grandpa and face him, he will be able to see you when you talk to him and that will help him understand you, too." Perhaps he can hear better in one ear, so you should remind children to talk into that one.

Sensations change

People's sense of touch also changes as they grow older. Hands retain sensitivity to touch longer, so grandparents may want children to kiss their hands rather than their cheek. Or they may want them to hold or stroke their hands.

A grandparent's reaction time may become slower, making it take longer to process information. Tell your child, "if you ask Grandpa a question, he may pause before answering. He has to sort out the question first."

What to talk about

Children may be concerned that they won't know what to talk about. Reassure them that their grandparents still want to hear about friends, sports, dance class, or school. They can even ask Grandma and Grandpa about their own early experiences.

Bringing photographs of your children in ballet costumes or baseball uniforms can enrich conversations. Giving the grandparent these photographs or pictures the children have drawn not only gives the grandparent a tangible reminder, but helps children realize they can give their grandparents pleasure.

Visiting a nursing home

If your older relative is living in a nursing home, you should talk with your children about what the home will be like. You should consider both the emotional and the physical impact the visit may have on them, and be sensitive to fears they may have.

Children should both be reassured about what to say to their grandparents and be prepared for the nursing home environment.

Talk about how it will look. Mention that there will be people sitting in wheelchairs and using walkers. There will be nurses to help care for the residents. It may even smell different, like a hospital.

Reassure children that Grandma still loves them, even if she calls them by a different name or doesn't seem to know them. Let your children know it is okay to cry if they feel upset. You should encourage them to ask you any questions they may have about their grandparents. Let them know they are free to express their feelings openly, without fear of being ridiculed or scolded.

If visiting a grandparent causes your children excessive stress, allow them to back away from the situation until they can handle it at a more mature age. If the nursing home environment makes the children extremely uncomfortable, try visits outside that setting, such as in your home or in an adult daycare situation.

Continued . . .

. . . *continued*

Sometimes parents don't recognize the value of visiting. People in nursing homes still want to have contact with the outside world, and it is important to keep the lines of communication open. Even those who are confused know when their family doesn't come to see them.

As you talk with your children, it is important that they see that older people have merit in this world. If you carefully prepare yourself and your children, nursing home visits can be rewarding for everyone.

Source: Judy Doulton is a free-lance writer.

Children's Books on Aging

One way to make your children more comfortable with their grandparents' aging is to read them stories about children in similar situations. Following are some books that may help children understand and cope when grandparents become physically and/or mentally disabled.

Now One Foot, Now the Other by Tomie di Paola (Putnam, 1981).

◆ Bobby's best friend was his grandfather, Bob. They built block towers together, and Bob taught Bobby to walk: Now one foot, now the other. After Bob has a stroke, his grandson teaches him how to walk, the same way he had been taught. Ages 4-8. To order, call (800) 631-8571.

Grandma Drives a Motor Bed by Diane Hamm (Whitman, 1987).

◆ Josh shares good times with his physically disabled grandmother, who is confined to a motor bed. In this realistic book, Grandpa, who is the primary caregiver, hollers once at Grandma but Mom explains, "even grandparents get frustrated and grumpy. Grandpa loves Grandma very much." Ages 4-8. To order, call (800) 255-7675.

My Grammy by Marsha Kibbey (Carolrhoda 1988).

◆ At first Amy is resentful when her Grammy, who has been stricken with Alzheimer's disease, moves in with Amy's family. With love, patience and understanding, Amy and her parents learn to accept Grammy's illness. Includes a short history of Alzheimer's disease and phone numbers for local chapters of related organizations. Ages 6-9. To order, call (800) 328-4929.

Always Gramma by Vaunda M. Nelson (Putnam, 1988).

◆ Gramma is in a nursing home now. She can't take care of herself anymore, and Grandpa can't take care of her at home. Her granddaughter visits her in the home often, but mostly this little girl remembers Gramma as she used to be. She remembers the songs they sang, the cakes they baked and all the good, close times they shared. Ages 4-8. To order, call (800) 631 8571.

My Grandma's in a Nursing Home by Judy Delton and Dorothy Tucker (Whitman, 1986).

◆ Jason's Grandma has Alzheimer's disease and must move to a nursing home. Grandma doesn't even remember Jason's name, and he hates his first visit to the home. In time, he comes to realize that Grandma and the other patients enjoy his visits, and, after a while, he does too. Ages 5-8. To order, call (800) 255-7675.

Grandpa Doesn't Know It's Me: A Family Adjusts to Alzheimer's Disease, by Donna Guthrie (Human Sciences Press, 1986).

◆ Lizzie adores her grandfather, who has Alzheimer's. He's always losing things and sometimes can't remember things, even who Lizzie is. Ages 5-8. To order, call (800) 221-9369.

Source: Barbara Goldberg, M.L.S., is a contributing editor to an independent parenting publication called *All Kids Considered*.

The Brown University Child and Adolescent Behavior Letter

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Resources

- A research monograph called "Including Children with Special Needs in Early Childhood Programs" synthesizes research on developing inclusive services that benefit all children. Topics include designing the environment, assessing children with special needs, implementing intervention practices and helping children with disabilities make the transition between programs. **Cost:** $8. **Contact:** Order #145, National Association for the Education of Young Children, 1509 16th St., NW, Washington, DC 20036-1426; 1-800-424-2460 or (202) 232-8777.
- An assessment tool that evaluates adolescents' risk for suicide places 13- to 18-year-olds in one of three risk classes: high, medium or low. To determine the classification, the Inventory of Suicide Orientation-30 (ISO-30) combines two scores: the overall level of orientation toward suicide, and the level of ideation. The ISO-30 is available in English and Spanish and in paper-and-pencil or on-line formats. **Cost:** $37. **Contact:** NCS Assessments, 5605 Green Circle Drive, Minnetonka, MN 55343; 1-800-627-7271, ext. 5151.
- The American Academy of Pediatrics' Committee on Injury and Poison Prevention revised its *Handbook of Common Poisonings in Children*. The third edition highlights poison prevention, general management of acute poisonings, drugs used in poisoned patients, toxicity calculations and information about 90 toxins and poisons, including medicines, drugs of abuse, chemicals and biological toxins. **Cost:** $44.95 ($39.95 for AAP members), plus $6.75 shipping and handling. **Contact:** American Academy of Pediatrics, 141 Northwest Point Blvd., PO Box 927, Elk Grove Village, IL 60009-0927; (708) 228-5005.

News Update

- The National Institute of Mental Health (NIMH) is planning to study the effect of a wide array of services on child and adolescent care, an effort made more pressing by the fragmentation of these service systems at local, state and federal levels. The $45 million, five-year, multi-site study of mental health service use, need, outcomes and costs for child and adolescent populations, referred to as UNO-CAP, will examine the prevalence of disorders and services available in six sectors: mental health, addiction, pediatrics, schools, juvenile justice and child welfare. (*Mental Health Weekly*, Jan. 16, 1995)
- Multeskins International of Stamford, CT, may be the first company to have developed and marketed adhesive bandages for people of color. The bandages are competitively priced, packaged in boxes of 30 and come in three shades: dark, medium and light brown. The bandages should already be available on the eastern seaboard. (*Practical Communications for Providers of Psychiatric, Alcoholism and Drug Abuse Services*, PO Box 742, Bala Cynwyd, PA 19004.)
- Members of the new Congress were handed a Contract with America's Children when they reconvened last month. Endorsed by more than 100 mainstream organizations serving children, the document asks each representative and senator to sign a promise that they will weigh children's needs first as they take up issues ranging from welfare reform to a balanced budget. (*The Washington Post*)
- Twenty-seven percent of Wisconsin high school students who took part in a survey say they seriously considered suicide during the previous 12 months, a state Division of Health publication reports. About a fifth of the surveyed students said that they even had planned how they would attempt suicide, according to *Wisconsin Health Statistics*. (Associated Press)
- The new childhood immunization schedule became effective last month. The vaccination schedule was recommended and endorsed by a working group that included the Advisory Committee on Immunization Practices, the Committee on Infectious Diseases of the American Academy of Pediatrics and representatives from the American Academy of Family Physicians. (CDC *Morbidity and Mortality Weekly Report*, Jan. 6, 1995)
- Milwaukee students attending private schools at taxpayer expense under a pilot choice program do no better scholastically than their peers in city public schools, according to a report by the Wisconsin Department of Public Instruction. Students using vouchers to attend private schools had slightly higher attendance rates, and they and their parents were happier with their schooling than students in public schools. But there was no difference in the two groups' academic performance. (*School Board News*, Jan. 17, 1995)

The Supreme Court in 1993-94

The 1993-94 U.S. Supreme Court Term resulted in a number of cases that may be of interest to psychologists. As an added service to you, *The Brown University Child and Adolescent Behavior Letter* is making this information available ***FREE*** to subscribers. These cases are summarized and clearly presented by Steven R. Smith, Dean and Professor of Law, Cleveland-Marshall College of Law, Cleveland State University. To obtain a ***free*** copy, call Meredith Baker, 1-800-333-7771.

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GUEST COMMENTARY

The risk of rewards

By Alfie Kohn

Many educators are acutely aware that punishment and threats are counterproductive. Making children suffer in order to alter their future behavior can often elicit temporary compliance, but this strategy is unlikely to help children become ethical, compassionate decision-makers. Punishment, even if referred to as "consequences," tends to generate anger, defiance and a desire for revenge. Moreover, it models the use of power rather than reason and ruptures the important relationship between adult and child.

Of those teachers and parents who make a point of not punishing children, a significant proportion turn to the use of rewards. Stickers and stars, A's and praise, awards and special privileges are routinely used to induce children to learn or comply with an adult's demands. As with punishments, the offer of rewards can elicit temporary compliance in many cases. Unfortunately, carrots turn out to be no more effective than sticks at helping children to become caring, responsible people or lifelong, self-directed learners.

Studies have found that behavior modification programs are rarely successful at producing lasting changes in attitudes or even behavior. Disturbingly, researchers have discovered that children whose parents make frequent use of rewards tend to be less generous than their peers. Indeed, extrinsic motivators do not alter the emotional or cognitive *commitments* that underlie behavior — at least not in a desirable direction.

Rewards are no more helpful at enhancing achievement than they are at fostering good values. At least two dozen studies have shown that people expecting to receive a reward for completing a task (or for doing it successfully) simply do not perform as well as those who expect nothing. This effect is robust for young children, older children and adults; for males and females; for rewards of all kinds; and for tasks ranging from memorizing facts to designing collages to solving problems.

The implications of this analysis and these data are troubling. If the question is "Do rewards motivate students?," the answer is, "Absolutely. They motivate students to get rewards." Unfortunately, that sort of motivation often comes at the expense of interest in, and excellence at, whatever they are doing. What is required, then, is nothing short of a transformation of our schools.

First, classroom management programs that rely on rewards and consequences ought to be avoided by any educator who wants students to take responsibility for their own behavior — and by any educator who places internalization of positive values ahead of mindless obedience. Second, assessment practices should help students experience success and failure not as reward and punishment, but as information.

In short, good values have to be grown from inside out. Attempts to short-circuit this process by dangling rewards in front of children are at best ineffective, and at worst counterproductive. Children are likely to become enthusiastic, lifelong learners as a result of being provided with an engaging curriculum; a safe, caring community in which to discover and create; and a significant degree of choice about what they are learning.

Alfie Kohn is the author of *No Contest: The Case Against Competition* and *Punished by Rewards: The Trouble with Gold Stars, Incentive Plans, A's, Praise and Other Bribes*, (Houghton Mifflin). This column is reprinted from the *ERIC EECE Newsletter*, published by the ERIC Clearinghouse on Elementary and Early Childhood Education, University of Illinois at Urbana-Champaign, 805 W. Pennsylvania Ave., Urbana, IL 61801-4897.

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

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Don't miss it!

The battered spouse may be male

By Henry B. Biller, PhD

Domestic Violence

Much of what's reported by the media gives a lopsided view of family violence, for the most part portraying males as the culprits but rarely as the victims. In fact, both men and women can be victims of maltreatment.

While family violence is an extremely serious problem, in the majority of families men and women do not engage in physically abusive behavior. When physical abuse does occur, however, men and boys are as likely to be victims as women and girls, according to some of the research done on family systems.

This does not mean that there should be any less attention directed to the terrible plight of battered women, and the inequitable gender power differential that often keeps them in abusive relationships. But it does call for a more balanced recognition that females are also much too often physically assaultive toward males in domestic situations.

Systematic sociological research reported by Murray Straus and others indicates that, on average, despite men being more aggressive outside of domestic relationships, women are at least as likely to initiate physically abusive acts within the household. Researchers find that in approximately 50 percent of abusive families, male and female adults are acting in a reciprocally aggressive fashion. Of the remaining households, about 25 percent reflect what is usually but misleadingly portrayed as the model situation, with men abusing relatively passive women. The other 25 per-

(turn to 2)

Poverty research has policy power

By Aletha C. Huston, PhD

Public Policy

In the United States, more than 20 percent of children live in poverty. It is serious, persistent and is associated with an array of problems, including low birth weight, infant mortality, contagious diseases and childhood injury and death.

Poor children are at risk for developmental delays in intellectual development and school achievement. Beginning in preschool, they tend to have lower average levels of school-related skills than non-poor children; their progress through school is slower and more subject to termination from dropout.

Poor children also have relatively high rates of social/emotional and behavioral problems, including anxiety, social withdrawal, aggression and delinquency; lack of self-esteem and self-efficacy; and psychological distress.

By adolescence, these problems can impinge on the larger society in the form of juvenile crime, early pregnancy and school dropout.

Many developmentalists interested in poverty want to do more than understand its effects; they want their research to have social impact — to help in reducing the negative effects of poverty on children.

(turn to 5)

This month's client handout: Bonding with your child is vital and rewarding

PS 025074

Domestic violence

from page 1

cent involve women being the consistently aggressive protagonists toward their male partners.

Compared to men, women are usually more at risk for serious injury, but even in the case of spousal murder, approximately 35 to 40 percent of victims are men killed by their female partners. Although in some families, women who severely injure or even kill men may be acting in self-defense, it is a mistake to assume that females only behave violently toward males when in need of protecting themselves or their children.

Father deprivation

Recent studies underscore earlier findings that mothers more often physically abuse children than do fathers. Moreover, boys are more frequently the victims of severe maternal physical abuse than girls. Certainly there is increasing evidence of both men and women maltreating children, but mothers more often batter, or even kill, their children, than do fathers. Although the Susan Smith case in South Carolina was bizarre in its details, maternal murder of children is not as rare as the public generally thinks.

The higher incidence of maternal, relative to paternal, physical abuse of children definitely reflects the reality of the great number of single-mother households, as well as two-parent homes where fathers are physically present but relatively uninvolved in child care. In fact, the most prevalent type of child maltreatment is paternal neglect.

Men and women who become rigidly fixated on another adult, usually of the other sex, are typically products of father-deprived households where they were extremely dependent on overworked mothers for their day-to-day emotional security. Despite O.J. Simpson's overlays of success, he was obsessed with his ex-wife. It's not a coincidence that he grew up fatherless: The breaking away of male children from exclusive attachment to their mothers often leads them to transfer their emotional dependency onto another female or to continue proving their masculinity by seducing women.

Similarly, paternally deprived women are more at risk to become overly dependent and abused by males because of their lack of positive childhood attachment to a man.

Inadequate fathering is linked with child maltreatment by mothers and others, within and outside the family. For example, maternal overrestrictiveness and other forms of mistreatment, including verbal and physical abuse, are highest in paternally deprived families, whether they be father-absent or two-parent families where mothers take virtually all child-rearing responsibility.

A review of the child sexual maltreatment research reveals that the likelihood of the victim having severe psychological problems and/or abusing others (including siblings) is much greater when there is also a history of physical abuse by either the mother or father.

Transient relationships

Much domestic violence involves men whose relationship to women and children is rather transitory.

A large proportion of violent households are those where the man and woman are not married and/or where one adult — typically the male — has not shared in the child-rearing responsibilities. Compared to those living with their own families, men who move in with women and children are more at risk to become physically abusive.

Boys and girls are as apt to witness domestic abuse initiated by mothers as fathers; they are as likely to see their mothers mistreat males as they are to see their fathers mistreat females. We must hold both men and women accountable and concentrate more of our efforts on increasing constructive male-female relationships inside and outside the family.

It is important to take a bio-psychosocial perspective, focusing on the interaction of constitutional predispositions, family backgrounds, and cultural factors, in understanding domestic abuse. The quality of the male-female partnership is a primary ingredient.

Positive perspectives

In societies where men and women are expected to play a nurturing role with infants and toddlers, there is less family violence and child mistreatment as well as crime against people and property. Overall, in this type of society, there are more supportive attitudes toward women, children and family life. When fathers (as well as mothers) have the opportunity to form close attachments with their infant sons and daughters, they are much less at risk to be abusive toward them during later development.

There needs to be a focus on the father factor and the two-parent advantage to address the interrelated problems of the paternal deficit and family violence in our society.

Therapy interventions and health initiatives, along with economic supports, Head Start programs and home-school partnerships, should underscore the importance of male and female adults positively sharing child-rearing responsibilities.

Much research indicates that patient communication of clear expectations by both parents is a much more effective way to teach a child self-control and moral values than is physical punishment or verbal intimidation.

Henry Biller is the author of *Fathers and Families: Paternal Factors in Child Development* (Greenwood Publishing Group, 1993). He is also the co-author of *Child Maltreatment and Paternal Deprivation: A Manifesto for Research, Prevention and Treatment* (Lexington Books, 1986) and, most recently, *The Father Factor: What You Need to Know to Make a Difference (Simon & Schuster*, 1994).

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Keep Your Eye On

... juvenile curfews.

Responding to an increase in juvenile violence, more than 1,000 jurisdictions across the nation have imposed youth curfews during the past five years, according to several recent news articles.

A U.S. Supreme Court decision in May let stand a lower court ruling that a Dallas, TX, curfew ordinance was constitutional. Since that decision, other cities have instituted curfews, and proposals for curfews are pending in several jurisdictions.

Debate continues over whether curfew laws are effective. A pilot program in East Los Angeles, in which juveniles under 18 are fined $675 for violating a 10 p.m.-to-dawn curfew, has led to a significant drop in crime and loitering, according to police. A Dallas police spokeswoman was quoted as saying, "We believe [the curfew] is working. ... We're not finding as many kids 8 to 10 years old on the street at 2 o'clock in the morning."

But curfew laws continue to draw criticism. The American Civil Liberties Union (ACLU), which was successful in getting a curfew ordinance in Miami, FL, struck down by a Florida appellate court, has argued that curfew laws violate the Equal Protection Clause of the U.S. Constitution by prohibiting juveniles from assembling in public areas, and take away parents' rights to raise their children as they see fit.

"More Cities Imposing Curfew Laws to Combat Juvenile Crime," *Juvenile Justice*, National Criminal Justice Association; (202) 347-4900.

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... domestic violence.

The legal system is failing to safeguard victims of family violence, concludes a new American Bar Association report. The report calls for mandatory arrests, prohibiting gun ownership by abusers and increased training for lawyers and judges. It challenges the legal profession to support reforms that include removing violent abusers and protecting parent victims from continued exposure to violence without risking loss of custody of their children. Every year, 3 to 10 million children witness violence in their homes, which can damage their psychological, cognitive and social development. For copies of the report, write for "The Impact of Domestic Violence on Children," No. 549-0248. The address is ABA Service Center, 750 N. Lake Shore Drive, Chicago, IL 60611, 1-800-285-2221; $8 includes shipping and handling.

... violence in schools.

A slight majority (51.6 percent) said violence is not a problem in their district, according to a 1994 survey of school board members. Among those who said violence is a problem, the larger the district, the higher the percentage of respondents who considered violence an issue. Respondents from urban districts, those with 5,000 or more students, and those from Pacific and Southern regions of the country were primarily the ones who perceived violence as a problem. Surprisingly, more than 80 percent of the respondents who considered violence a problem said students feel safe at school, with those who live in the suburbs being most likely to say so. (*The American School Board Journal*, January 1995)

... the HIV virus.

The risk of acquiring HIV, the virus that causes AIDS, may be significantly higher during sex with someone who was infected within the past 60 days, according to a recent study by University of Michigan researchers. People are most infectious during the first two months after acquiring the virus — the primary phase of the infection — and they appear to be far more infectious during this phase than scientists previously believed, according to the study. Rates of infectivity during the primary infection phase may be as much as 100 to 1,000 times higher than in the long asymptomatic phase that follows, which can last for years. Among homosexual males, the rates of infectivity during the initial phase may be as high as three out of 10 sexual encounters, according to the study. (*Journal of Acquired Immune Deficiency Syndromes*, November 1994)

... teen gambling.

At the same time that gambling among young people is raising concern of school administrators, gambling is raising funds for school coffers. Forty-eight states — all but Hawaii and Utah — permit gambling in some form, and while some states simply pour the revenue into the state treasury, others earmark them for educational and environmental programs. In Florida and California, for example, state lottery earnings are supplanting tax dollars in school district budgets. (*School Board News*, Aug. 30, 1994)

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At the Library

By Barbara Goldberg, MLS

Being "gifted" doesn't always seem like such a good thing. Sometimes children resent being separated from their friends, being singled out as "different," and feeling like they have to meet others' expectations.

The following helpful books can be found at most public libraries.

213 Valentines by Barbara Cohen. Henry Holt, 1991. Wade, a gifted black fourth-grader, isn't happy about having been transferred to the special gifted and talented program in a different school where he has trouble making friends. Thinking he won't receive any valentines, he plans to send some to himself — 213 of them — all signed by such famous people as Jackie Robinson, Eddie Murphy, Malcolm X and Nelson Mandela. Grades 2-4. 1-800-488-5233.

Dear Dad, Love Laurie by Susan Beth Feffer. Scholastic, 1989. When Laurie's best friend is invited to be in the gifted and talented program and Laurie isn't, she makes extreme (and usually humorous) efforts to be recognized for the program. Her sixth-grade year is recorded in weekly letters to her divorced dad. Grades 4-6. 1-800-325-6149.

Maizon at Blue Hill by Jacqueline Woodson. Delacorte, 1992. Gifted seventh-grader Maizon wins a scholarship to an expensive academically challenging boarding school. Being only one of five African-American girls in the school, she finds it difficult to fit in and faces questions on racism, money and friendship. Trying to explain her feelings to her white roommate, she thinks, "It felt like there were a million miles between us. But the miles weren't about distance, they were about knowledge and experience, and pain." And Maizon doesn't want to disappoint her grandma either by leaving school. Grades 5 and up. 1-800-323-9872

Here's to You, Rachel Robinson by Judy Blume. Orchard Books, 1993. Rachel, the ideal achiever in a competitive family, wonders what it would like to be a "regular person" for just one year. Would her mom be disappointed? Pressures from family, school and friends add up as everyone expects and wants her to do something. Grades 6 and up. 1-800-621-1115.

I Hate Being Gifted by Patricia Hermes, Putnam, 1990. The LEAP (Learning Enrichment Activity Program) takes you away from your friends and makes you feel left out. Unhappy at being singled out and separated from her sixth-grade friends, K.T. desperately wants out of the LEAP program, known as Leap Creeps by those not in it. Deserted by her closest friends who are being drawn away by Erica, who says she failed the LEAP test on purpose and starts her own club as self-appointed president, K.T. learns to stand up for herself, her beliefs and other LEAP participants. Young adults. 1-800-847-5515.

Face the Dragon by Joyce Sweeney. Delacorte, 1990. Six kids enter high school in an accelerated program for gifted students, and each must face his or her own dragon, including possible homosexuality, poor self-confidence, and not being able to achieve a goal no matter how hard one tries. Young adults. 1-800-323-9872.

Barbara Goldberg is a contributing editor to *All Kids Considered*, an independent parenting publication.

Speaking of Books

Textbook of Pharmacotherapy for Child and Adolescent Psychiatric Disorders
R. Rosenberg, J. Holttum, S. Gershon
New York: Brunner/Mazel
570 pages, $65 (hard), 1994
To order, call 1-800-825-3089

At a time when the use of drug therapy for behavioral and emotional problems of young people is at an all-time high, and when much debate is occurring about the relative efficacy of medications, psychotherapy, and joint effects of these on various disorders, this highly authoritative work on drug effects, side effects, and consequences of overdose should help.

The Evolution of Desire: Strategies of Human Mating
D.M. Buss
New York: Basic Books
262 pages, $22 (hard), 1994
To order, call 1-800-331-3761

Why do humans fall in love, and what keeps them there? The evolutionary psychologist finds that what women want differs from what men want. This is a book as much about sexual and spousal conflict as about love. Mating behavior across cultures was explored to provide the data base for this book, with more than 10,000 people surveyed.

Student Aggression
A.P. Goldstein, B. Harootunian, J.C. Conoley
New York: Guilford Press
280 pages, $28.95 (hard), 1994
To order call, 1-800-365-7006

School violence and vandalism have escalated enormously in recent years. This volume is about successful programs for preventing and managing student aggression. The antecedents of violence are discussed, along with student-oriented interventions, skills training, behavior modification, psychodynamic interpretations, and other systems preventatives.

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Poverty

from page 1

Those with policy interests are living in the right era. Funding policies of the federal government and private foundations have shifted toward emphasizing research that addresses social problems and has social applications.

Make it multidisciplinary

In order to play in the policy game, research must be multidisciplinary. Specialists in health, child development, social welfare, family development, economics and other disciplines each have a contribution to make. It is especially important to incorporate economic analyses, because economic considerations often drive policy decisions.

For example, there is a strong body of research showing that early educational child care and intervention programs have positive and lasting effects on children's school achievement. But that knowledge alone is insufficient, because policymakers must consider cost.

Cost-effectiveness and cost-benefit analyses of early childhood intervention programs *have* been conducted. Economists have collaborated with developmentalists to determine the short- and long-term economic benefits of infant and preschool programs. For instance, a cost-benefit analysis of the Perry Preschool Project, a preschool program designed to promote the intellectual development of poor children, demonstrated that, by the time the children in the study were 19 years old, the estimated value of the program was $9,500 per child in 1981 dollars.

Welfare reform

Developmentalists are just beginning to collaborate in another stream of research — the study of welfare reform. Until recently this research was dominated almost entirely by an economic orientation. Social science evaluations played an important role during the 1980s, for example, in guiding the formulation of federal welfare policies that culminated in the Family Support Act of 1988.

Reform efforts were (and still are) focused on education and training programs designed to help recipients of Aid to Families with Dependent Children (AFDC) become self-supporting. Several carefully designed large-scale experiments showed that women achieved modest gains in work hours and income as a result of education and training programs. But, though technically sound, these studies suffer from one major weakness: the indices of success are limited to economic effects — changes in income, employment for mothers, and reductions in AFDC costs.

Effect on parenting

Job training programs in some states require participation by mothers of children as young as 1 year of age, and some current federal proposals would set mandatory participation for adolescent mothers at 12 weeks after an infant's birth. Yet, there is little or no information about the consequences for the children in participating families.

A few developmental researchers have recently forged connections with field experiments testing welfare-to-work programs. In three current studies, for example, videotaped observations of mother-child interaction are being collected to evaluate the effects of participation in education and job training interventions on mothers' parenting behavior.

Developmentalists also have changed the conceptualization of the problem from training mothers to be self-sufficient to providing a two-generation intervention affecting both short- and long-term probabilities of continuing poverty.

Translation to policy

Psychologists sometimes assume that making research "applied" is sufficient to contribute to policy, but applied research may have little impact unless it addresses policy issues directly. Policy research, more narrowly defined, is "research on, or analysis of, a fundamental social problem in order to provide policymakers with pragmatic, action-oriented recommendations for alleviating the problem," according to Ann Majchrzak, author of *Methods for Policy Research* (Sage, 1984). Policy research explicitly investigates factors that are amenable to public policy influence.

For example, there is now a body of literature showing a relationship between quality of child care and cognitive and social development. Psychologists like to measure child care quality directly by observing the child care environment and the human interactions experienced by the children there. But one goal of the research is to inform policies about the regulation of child care; other indices of quality that are "regulatable," like ratios, group size or caregiver training, should be included along with the more direct, observable indices of quality.

One group of investigators studied this relationship between observed quality and the regulatable quality indicators within child care centers serving different income groups. Centers serving low-income children were similar to high-income centers on indices like ratios and group size, but the index based on observed adult-child interaction indicated lower quality. This study raises questions of how quality can be evaluated and regulated equitably for different groups in the society.

Aletha Huston is University Distinguished Professor of Human Development at the University of Kansas. She is the editor of *Children in Poverty: Child Development and Public Policy* (Cambridge University Press, 1991). This article was excerpted from the summer 1994 issue of *Social Policy Report*, a publication of the Society for Research in Child Development. For a copy, contact the SRCD executive office at the University of Michigan, 300 N. Ingalls, 10th Floor, Ann Arbor, MI 48109-0406.

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WHAT'S NEW IN RESEARCH

Parents' divorce leaves lasting impact

Young adults who grew up in divorced families can be emotionally distant from their parents, and yet, ironically, unable to separate from them, according to a new study. Finding "emotional middle ground" by differentiating from one's family of origin without emotionally cutting off from it is one of the most critical tasks of young adulthood, and it may be more difficult after parents divorce, the study suggests.

"It may be that continued family conflict ... interferes with the development of healthy parent-child relationships by keeping the generations connected through anger and discord, which further reinforces an emotional cut-off," said the New Mexico State University researchers, who presented their findings at the American Psychological Association's annual conference last summer. "Thus, the parent-child relationship is unsatisfactory and distant, but also undifferentiated and connected through anger."

Not only that, but divorce appears to leave another legacy to young adults: They seem to have a hard time maintaining intimate and individuated relationships with their own spouses and partners. "The lack of healthy differentiation in the adults' relationships with their parents appears to continue in their relationships with their significant others," say the researchers.

They interviewed 119 college students: 38 whose parents had divorced at least once and 81 from intact families. The students — 31 men and 88 women — ranged in age from 19 to 53 years, with an average age of 24. Forty-four identified theselves as Hispanic, and 75 as Anglo. Of the 38 students whose parents were divorced, 25 grew up in single-parent families, while 13 lived in stepfamilies. Parents had divorced an average of 15 years before the time of the study.

The students were given the college version of the Personal Authority in the Family System Questionnaire (PAFS-Q), which measures perceptions of family and peer relationships. Family conflict was measured with the conflict subscale of the Family Environment Scale (FES).

Parents' marital status turned out to be a significant predictor of four of the seven PAFS-Q subscales. When compared to students from intact families, adult children of divorced parents showed less:

- **Intergenerational intimacy:** the degree of intimacy and satisfaction with parents.
- **Intergenerational individuation:** the degree of differentiation of self in relation to parents.
- **Peer intimacy:** the degree of intimacy and satisfaction with spouse or significant other.
- **Peer individuation:** the degree of differentiation of self in relation to spouse or significant other.

These findings have implications for counselors working with adults whose parents are divorced. Counselors may need to help these clients reach that tricky emotional middle ground. "It seems particularly appropriate for counselors to encourage adults from divorced families to set firm boundaries with their parents to avoid being triangulated or participating in reactive exchanges which perpetuate a lack of differentiation in the relationships," the researchers said.

"The impact of parental divorce on the attainment of developmental tasks of young adulthood," Patrick Johnson, MS, William K. Wilkinson, EdD, and Keith McNeil, PhD. For reprints, write to the authors at the Department of Counseling and Educational Psychology at New Mexico State University, Box 30001/Dept. 3CEP, Las Cruces, NM 88003-0001.

Girls who attempt suicide have complex diagnoses

Comorbidity was common among a group of adolescent girls hospitalized for suicide attempts. More than half of the 140 girls presenting for treatment at an inner-city suicide disorders clinic were diagnosed with disorders from at least two of the following diagnostic categories: affective, anxiety or disruptive. Those with affective disorders showed higher levels of depression, ideation, impulsivity, greater concern and lower self-esteem and family cohesion than their non-depressed peers. Anxiety or disruptive disorders were weakly associated with individual and familial psychopathology, and the presence of a disruptive disorder was related to adolescent reports of impaired family function and poorer relationships with their mothers. Researchers say that identifying specific diagnostic subgroups and risk profiles among suicidal adolescents is important in improving treatment protocols.

"Diagnostic subtypes among female adolescent suicide attempters," J. Piacentini, PhD. Presented in poster session at the most recent conference of the American Psychiatric Association. For reprints, contact Piacentini, New York State Psychiatry Institute, Columbia University, 722 W. 168th St., New York, NY 10032.

Adjustment disorder is not stable diagnosis

Many patients with adjustment disorders are highly suicidal on admission to psychiatric hospitals, but their stay is likely to be short, suggests a new study. Researchers looked back at charts of patients who had been admitted to an acute psychiatric service in 1989. The 102 adults and 54 children with adjustment disorders did not differ from an age- and sex-matched control group in terms of marital status, ethnicity, religion, commitment status or discharge disposition. Both children and adults with adjustment disorder diagnoses had shorter hos-

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pitalizations than controls — an average of 20 days, compared to 32 days for child controls and 44 days for adult controls. The patients with adjustment disorders also had suicidal ideation or behavior on admission more often than controls. Adults, but not children, were more often diagnosed with a substance abuse disorder than controls. Adults also had significantly fewer psychiatric readmissions and less total readmission length-of-stay than controls two years after their discharge. Forty percent of patients admitted with adjustment disorders were discharged with the diagnosis; only 6 percent of controls were changed to adjustment disorders on discharge. In cases where patients originally diagnosed with adjustment disorders were readmitted to the hospital, only 18 percent were again diagnosed with adjustment disorders. That suggests that adjustment disorders are unstable diagnoses.

"Adults and children admitted with adjustment disorder diagnoses: clinical correlations and two-year rehospitalization," David N. Rosenfeld, MD, et al. Presented in poster session at the most recent conference of the American Psychiatric Association. For reprints, contact Rosenfeld at Psychiatry, Bergen Pines City Hospital, 230 E. Ridgewood Ave., Paramus, NJ 07652.

Which patients won't comply with treatment?

More than a fourth of young patients in a recent study did not comply with the recommendations of their psychiatric evaluation, and the compliance rate varied with the reason they were referred to the child psychiatry unit. Researchers reviewed the charts of 285 patients, ages 2 to 18 years. They found that 41.9 percent of somaticizing patients were non-compliant, compared to 12.5 percent of those with suicidal ideation. The researchers postulated that the implications of suicidality may encourage compliance. By contrast, they suggested, somaticizers may deny that their illness has a psychiatric component, possibly explaining their high non-compliance rates. The researchers said a consultation/liaison clinic within pediatrics departments may help promote compliance by making treatment easily accessible.

"Compliance patterns in a child psychiatry outpatient consultation/liaison unit," Ilisse R. Perlmutter, MD, et al. Presented in poster session at the most recent conference of the American Psychiatric Association. For reprints, contact Perlmutter at Psychiatry, NYU Medical Center, 178 E. 80th St., Apt. PH-F, New York City, NY 10021.

Resources

- A California community is sharing its ideas on creating safe homes, schools, neighborhoods and workplaces. "Preventing Violence in Contra Costa County: A Countywide Action Plan and a Framework for Action" outlines how communities and government can work together to integrate and expand violence prevention activities. The action plan was placed on the November ballot by the county's board of supervisors and was overwhelmingly approved by 78.5 percent of the voters in Contra Costa County, a racially and economically diverse county in the greater San Francisco Bay Area. **Cost:** Free. **Contact:** Action Plan, Contra Costa County Prevention Program, 75 Santa Barbara Road, Pleasant Hill, CA 94523, (510) 646-6511.
- Two new publications address reproductive health issues in an easy-to-read, multicultural text designed for varied reading levels. *What Is Right for You: Choosing a Birth Control Method* provides the latest information on 13 contraceptive methods, including Norplant, Depo-Provera and the female condom. *STDs: What You Need to Know* features the latest public health guidelines on preventive health behavior. Spanish language adaptations are available. **Cost:** Birth control, $.70 each for up to 500 copies; STDs, $.55 each for up to 500 copies. Call for other bulk rates. **Contact:** Education Program Associates, 1 W. Campbell Ave., Bldg. D, Campbell, CA 95008, (408) 374-3720.
- A non-profit organization's reference service provides extensive citations from classic to contemporary research and clinical reports on such subjects as infant psychosocial care, preparation of children for hospitalization and surgery, and adolescents in health care. **Cost:** Varies; free listing of available topics with self-addressed, stamped envelope. **Contact:** Pediatric Projects Inc., PO Box 571555, Tarzana, CA 91357-1555, 1-800-947-0947.
- Early childhood professionals can use a new series of books to help children deal with emotions. The series comprises 21 books in seven sets: anger, fear, grief, guilt, hurt, loneliness and jealousy. Each set includes a picture book, a children's activity book and parent's guide. **Cost:** $150. **Contact:** Enchanté Publishing, 1-800-4-READ ME.

Readers' Response

Kohn's 'Risk of Rewards' revisited

Alfie Kohn's guest commentary, "The Risk of Rewards," (February 1995, page 8) brought overwhelming response, some in agreement, some not, but all fascinating. We are reserving a full page in next month's issue to bring you a representative sample of the responses we have received. You can be sure they are interesting. Look for it in your April issue of *The Brown University Child and Adolescent Behavior Letter.*

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GUEST COMMENTARY

Protect youth against reckless change

By Marian Wright Edelman

Congress is on the verge of embracing the most callous public treatment of poor children in decades. All of us who care about the future of this nation must take quick, concerted action to convince Congress not to destroy 50 years of bipartisan work to protect children and families.

Today's threats are far more fundamental than the budget cuts of the 1980s. Spending cuts can be reversed. Changing our Constitution and destroying the federal guarantee of minimal survival benefits to our poorest children would have far more serious and lasting effects. If proposals to abandon the assurances of help contained in the Aid to Families with Dependent Children, food stamp and child nutrition programs are successful, the consequences for poor children and families would be devastating for generations to come.

As "entitlements," welfare, food stamps and child nutrition programs now are guaranteed to all eligible children who apply. But the Contract with America and other proposals now before Congress would sweep away those guarantees. Entitlements and other federal programs would be combined into several capped block grants, and spending ceilings would be set at levels well below the amounts currently spent on the individual programs. The grants would be distributed to the states in lump sums, with few restrictions on their use.

The amounts of the grants would be fixed, so if a state ran short of funds to meet a rising need for food stamps, school lunches or welfare assistance — because of a recession, disaster or plant closings, for example — it would have to cut services, make fewer children eligible or create waiting lists for vital services. How can any thinking person *not* expect the number of poor, hungry, sick and homeless children to skyrocket under such policies? It was precisely to protect our poorest citizens from the vagaries of short-term budget politics that our federal government made welfare and food programs entitlements in the first place!

This is not to argue against change. With the proper safeguards, some children's programs could be consolidated in a way that would both make them more effective and protect children's best interests. Such *responsible* change, however, requires time and serious thought, not a headlong rush to act within 100 days.

As children's advocates, we must form a united front to force the politicians to slow down, define their goals and explain the outcomes they seek to foster. We must insist that they provide solid evidence that their proposed strategies will help children, not just wealthy corporate interests.

You can help by making sure advocates in your state visit and educate *every* member of your state's congressional delegation about the needs of children. Arrange for members to visit a Head Start or WIC center or talk with a welfare family so they will better understand how their decisions will affect the lives of real children in their own communities.

Americans did not vote in November to codify callousness toward poor, sick, hungry or homeless children. We child advocates must make sure Congress does not unfairly balance the budget on the backs of children and the poor.

Marian Wright Edelman is president of the Children's Defense Fund. This commentary was reprinted from the organization's newsletter, *CDF Reports*, January 1995. You can contact CDF at 25 E St., NW, Washington, DC 20001, (202) 628-8787.

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Children who don't fit in need help

By Marshall P. Duke, PhD and Stephen Nowicki Jr., PhD

Clinical Issues

We all know children who just can't seem to get life "right." They really want others to like them, but the harder they try, the worse they seem to do. They are like pieces of a puzzle that do not fit with the others. They are the square pegs, the fifth wheels, the ones picked last for teams, the ones who sit alone in a corner of the playground, wondering why others don't like them and why they're treated as if they don't exist.

Many of these children who want so badly to belong — but are somehow failing to develop the kinds of friendships so necessary to be happy and well-adjusted — may be suffering from what we call *dyssemia*.

"Dyssemia" is a term that, like "dyslexia" (*dys-* = difficulty; *-lexia* = reading), describes a difficulty in the use of nonverbal signs (*-semia*). This communication deficit is a sort of body language version of dyslexia that prevents children from interacting with others in positive ways. Included in nonverbal social communication is rhythm and use of time, personal space, gestures, postures, facial expressions, tone and loudness of voice, and dress and hygiene.

Children can suffer from some form or combination of expressive

(turn to 2)

Shaffer, Pfeffer discuss teen suicide

By Leah Wallach

Prevention

Several investigators are studying the correlates of teen suicide to try to understand the lives behind the deaths. Adolescent suicide can best be understood as a rare complication of more common problems, according to David Shaffer, MD. And problems such as mood disorders are exacerbated by problems like alcoholism. Together, they can make a potentially lethal mix.

Shaffer and colleagues at the New York State Psychiatric Institute gathered information about the mental health of 170 teenagers who committed suicide over a two-year period. They extensively interviewed the victims' relatives and friends to paint a psychological portrait of these young people.

The vast majority — 90 percent of the boys and 91 percent of the girls — had a psychiatric diagnosis. The three most common were:

- **Depression:** 60 percent of the boys, 68 percent of the girls.
- **Antisocial personality disorder:** manifested by violent outbursts, assaultiveness, frequent running away, etc. Fifty-four percent of the boys, 36 percent of the girls.
- **Substance abuse:** usually alcohol. Forty-two percent of the boys and 12 percent of the girls, compared to 5 and 8.9 percent in the general population.

Comorbidity was the rule. In most of the suicides the diagnosis of a mood disorder co-occurred with either a substance disorder or antiso-

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This month's client handout: Fear and fearlessness in children

Fitting In

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and/or receptive nonverbal language deficit. They either cannot transmit or "read" the customary nonverbal signals necessary for successful interpersonal relationships. Compared to verbal communication, nonverbal communication is more continuous, more out of awareness, more likely to be believed by others and more involved with emotion. For this reason, dyssemias can have a serious negative impact on relating to others.

We believe that only a small proportion of dyssemias originate from neurological sources. Most dyssemias come about because children do not have access to appropriate situations and experiences necessary to learn the particular nonverbal skill. And the emotional impact of events such as parents' divorce and the death of a close relative can negatively affect the learning of appropriate nonverbal communication and cause dyssemias to develop.

Because most nonverbal social processing deficits are learned, it means that if they can be identified, they can be remediated. In identifying possible indicators of a dyssemia, look for the child who:

- is often described by parents and teachers as tactless and insensitive.
- is often described by other children as "dumb," but usually has average or above-average intelligence.
- is often described by parents as being "different" since infancy.
- is often seen by parents and teachers as lacking in social maturity.
- often has difficulty perceiving danger.
- often has difficulty understanding when something is a hazard.
- often has difficulty understanding rules and sequences of games.
- often has difficulty recognizing the contingency between his or her behavior and its consequences.
- often feels sad, bewildered, lonely, confused, anxious or different.
- often perseveres in action or activity even when it leads to punishment or failure.
- is inconsistent — will be accurate in one form of nonverbal communication one day but not the next.

Children also can be asked to interpret the emotions being communicated on television with the sound and picture alternately turned off. Parents or teachers can engage in informal discussions with children about the nonverbal behaviors of people observed in shopping malls or children on playgrounds through which they can assess whether the child is accurately reading the communications of others.

Once it has been determined that a dyssemia exists, the correction procedures usually are built around three steps.

1. The child should be made aware of the problem and what you as the tutor are going to do to help remediate the difficulty.
2. The child should practice the exercises developed to remediate the nonverbal social processing deficit. We offer a number of specific suggestions for remediation exercises.
3. The child's progress should be monitored in applying what has been learned to the real world.

Remediation thus consists of a process of awareness, practice-verbalization and repetition until the nonverbal skill is learned. Remember that children can suffer from more than one dyssemia, and if informal assessment and remediation is unsuccessful, then more formal procedures with a professional may be needed.

Marshall Duke and Stephen Nowicki Jr. teach in the psychology department at Emory University in Atlanta.

News Update

- The cheerleading squad at Kettle Moraine High School in Wales, WI, has been disbanded because only three of the 17 girls were willing to brave the taunts, epithets and objects hurled at them by fellow students. Squad sponsor Karen Witkowski wondered what kind of a message the disbanding sends to the antagonists. "What they have learned is if they harass people enough, they go away," she said. (*The Executive Educator*, February)
- Disruptive and troublesome middle schoolers in Philadelphia will be sent to six pilot schools that will have a 15-to-1 student-to-teacher ratio, no more than 50 children in a school, and more counseling. Some residents in the community are upset by the proposal, which they say turns their neighborhood into a landfill for troubled kids. (Knight-Ridder)
- Many cases of mental retardation with no known cause soon may be detected, if a team of Anglo-Canadian psychiatrists and geneticists are right. They have pinned 3 percent of these cases to genomic abnormalities at the extreme tips of human chromosomes. Most of the inherited mental retardation today is accounted for by Down's syndrome, Fragile X and similar syndromes. (*BioWorld Today*)
- Students who drop out of school are more likely to engage in risky sexual behavior that increases their chances of getting sexually transmitted diseases, including HIV, according to researchers from the University of Miami School of Medicine. They surveyed students in two Miami dropout prevention programs and found that these students were more likely to have had sex, have had sex younger and to report two or more partners during the

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preceding three months than their peers in the community public high school system. (*Morbidity and Mortality Weekly Report*, Dec. 2, 1994)

- A better understanding of how the brain distinguishes stimuli that vary rapidly over time — like speech and music, for example — may lead to new interventions for learning disabled children, according to neuroscientists from the University of California at San Francisco. Their computer models of the brain's neural circuitry were able to distinguish differences in time-dependent stimuli. They theorize that learning disabilities in children result from problems in processing normal speech cadences. (*Science*, Feb. 17)
- Students at two suburban Detroit high schools might have to take breath tests if administrators believe they have been drinking alcohol. Grosse Point North High School Assistant Principal Thomas Teetaert says his school and Grosse Point South High School are considering the use of Breathalyzers to curb drinking among students. The idea would have to be approved by the school board first. (UPI)
- A father who takes little part in the care of his daughter, especially while she's a preschooler, is much more likely to sexually abuse the child than a father who is actively involved in child care, according to psychologists at the University of New Hampshire in Durham. This link between minimal caretaking and incest holds true regardless of a man's childhood physical or sexual abuse by his own parents, inability to empathize with others, emotional instability, marital problems or negative attitudes toward a daughter before her birth. (*American Journal of Orthopsychiatry*, January)

KEEP YOUR EYE ON

... trends in risky sex.

Although the proportion of sexually experienced adolescents increased substantially during the 1980s, the number has stabilized and more of them are using condoms, according to a survey by the Centers for Disease Control and Prevention (CDC).

From 1990 to 1993, the percentages of high school students remained constant for those who reported ever having had sexual intercourse (averaging 53.8 for the three years), ever having had sex with four or more partners (average 18.8 percent), having had sex during the three months preceding the survey (average 38.2 percent), having used alcohol or drugs before the last time they had sex (average 11.4 percent) and having used birth control pills during the last time they had sex (average 16.9 percent).

By contrast, the percentage of those who reported condom use at last sexual intercourse increased significantly, from 46.2 percent in 1991 to 52.8 percent in 1993. However, analyses of subgroups indicated a significant increase in condom use only among girls (38 percent to 46 percent) and blacks (from 48 percent to 56.5 percent). Among white boys, the rate of condom use was less dramatic: from 46.6 percent to 52.3 percent. The study did not address other factors, such as education and economic and cultural influences, that could have produced differences among subgroups.

In the 1991 and 1992 surveys, two health outcomes associated with risky sex — teen parenthood and gonorrhea — decreased. Overall, live-birth rates among 15- to 19-year-olds decreased by 2 percent, and gonorrhea rates decreased significantly among both young men and women (20 percent and 13 percent, respectively).

Despite these findings, many adolescents continue to be at risk for HIV infection, other sexually transmitted diseases and unintended pregnancy because they engage in unprotected sex.

Morbidity and Mortality Weekly Report, Feb. 24, 1995.

... innovative programs.

The principal of Clear View Elementary School in Chula Vista, CA, credits a program called Peace Patrol with decreasing student discipline referrals to her office by 95 percent in one school year. Developed by Eden Steele, a teacher at the school, the program won a Golden Bell Award and is used in more than 17 surrounding schools.

The idea of Peace Patrol is to teach students to be effective problem-solvers and to train them in positive decision-making. Students are shown how to settle their own conflicts with the help of trained student mediators. They are also provided with alternatives to gangs and antisocial behaviors.

Designed for fourth- through sixth-graders, Peace Patrol stresses five basic elements: building self-esteem, teaching cooperation, teaching other students about conflict resolution, training new members and holding workshops for parents and other community members. Program trainees also study the similar and diverse aspects of other cultures' customs and attitudes.

A step-by-step guide for setting up and administering the program is available from the Wisconsin Clearinghouse. Call 1-800-322-1468.

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Resources

- *Exceptional Parent* magazine's annual resource guide describes more than 1,000 resources and services for parents and professionals who serve the needs of children and young adults with disabilities and special health care needs. **Contact:** Exceptional Parent, 120 State St., Hackensack, NJ 07601-5421, 1-800-E-PARENT. **Cost:** $9.95.
- The National Association of Social Workers has launched a public service campaign to help children understand the causes of violence and to offer suggestions for individual action. The campaign, called "Stopping Violence Starts with Me ... And Ends with Us!," describes activities for a range of ages. **Contact:** NASW, 750 First St., NE, Suite 700, Washington, DC 20002-4241, (202) 408-8600.
- A million copies of a pamphlet called "A Guide to Partying" are being distributed to young Americans as part of the National Institute on Drug Abuse's national "Get High, Get Stupid, Get AIDS" drug abuse and AIDS prevention campaign. The pamphlet offers strategies for safe partying. **Contact:** National Clearinghouse for Alcohol and Drug Information, PO Box 2345, Rockville, MD 20847-2345, 1-800-729-6686. Ask for stock #PHD622.
- A new classroom guide, "On Trial in California: The O.J. Simpson Case," offered by the American Bar Association's National Law-Related Education Resource Center, covers such topics as jury selection, the difference between direct and circumstantial evidence, the role of expert witnesses, the meaning of "beyond reasonable doubt," and what, if anything, the defense must prove. **Contact:** ABA publications, (312) 988-5522.

Announcements

Scholars program seeking development researchers

The William T. Grant Foundation is looking for up to five investigators whose research contributes to the understanding of the development and well-being of children, adolescents and youth. Awards are for five years, totaling $175,000. Applicants should be junior or pre-tenure, not established investigators, in tenure-track positions. For a copy of the brochure outlining the application process, contact: Faculty Scholars Program, William T. Grant Foundation, 515 Madison Ave., New York, NY 10022-5403. The deadline for applications is July 1.

NSF to fund more basic research in human behavior

The National Science Foundation has launched a major new research agenda to further advance fundamental scientific knowledge about human behavior. Under its Human Capital Initiative (HCI), NSF plans to make more than 60 new awards totaling at least $8 million to social and behavioral scientists this year. HCI is organized into six social contexts: workplace, education, discrimination, families, neighborhoods and poverty. For more information, call one of the following people, depending on your research interest: Joe Young, human cognition, (703) 306-1732; Leslie Zebrowitz, social psychology, (703) 306-1728; or Bonney Sheahan, interdisciplinary research, (703) 306-1733.

1995 summer workshops set

1995 summer workshops for educators are set at Landmark College's Vermont campus on effective techniques for teaching college and high school students with dyslexia, ADHD and specific learning disabilities. For more information, contact Jim Olivier at (802) 287-6762.

Speaking of Books

Annual Progress in Child Psychiatry and Child Development: 1994
New York: Brunner/Mazel
600 pages, $64.95 (hard)1995
To order call, 1-800-825-3089

The next in this ageless series of volumes, reprinting what the editors consider the best of the literature of the year. The editors' taste is the critical factor here. Among the excellent selections included are: Ceci and Bruck's "Suggestibility of the child witness: A historical review and synthesis," Elizabeth Loftus's "The reality of repressed memories," and Achenbach's "Nine-year outcome of the Vermont intervention program for low birth weight infants."

A Toddler's Life: Becoming a Person
Marilyn Shatz
New York: Oxford University Press
221 pages, $35 (hard), $14.95 (paper), 1994
To order, call 1-800-451-7556

An intimate account of a child's development from age 1 to 3, emphasizing the unique capacity of humans to reflect on themselves and to self-regulate based upon those thoughts.

Nature, Nurture and Psychology
R. Plomin and G.E. McClearn (Eds.)
Washington, DC: American Psychological Association
498 pages, $49.95 (hard), 1993
To order, call 1-800-374-2721

Critical new studies have appeared in the past 10 years concerning the origins of individual differences. Major figures in the science of hereditary and experiential influences on development, cognitive ability, personality, temperament and psychopathology here discuss new findings and their interpretations. Authors include Bouchard, Bronfenbrenner, Ceci, Lykken, Kimble, Rutter, Kagan, Gottesman and Reiss. A remarkably fine compendium.

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Prevention

from page 1

cial personality disorder or both. Similarly, Cynthia Pfeffer, MD, of New York Hospital's Westchester Division and her colleagues found that mood disorders increased the risk of adolescent suicide attempts five times, and substance abuse increased the risk 2.8 times.

Shaffer suggests that alcohol abuse may play an important role in the suicide equation. He notes that in his sample, rates of alcohol abuse soared among the 18- to 19-year-olds. Two-thirds of those in this age group who killed themselves had had problems with alcohol, significantly more than the control subjects. In the general population, half of all teen suicides occur among 18- and 19-year-olds.

Another well-established and important suicide risk factor for individuals of all ages is the suicide or attempted suicide of a first- or second-degree relative. Shaffer's group found that other negative life experiences had no or little relation to suicide in adolescents.

However, they did find that the children who killed themselves had significantly poorer communication with their parents than controls, apparently a consequence of social withdrawal associated with depressed moods. Pfeffer's group found that poor social adjustment (poor relations with others) increased the risk of suicide among adolescents about four times.

To better understand the developmental history of suicidal behaviors and to explore possibilities for early intervention, Pfeffer and her colleagues have identified prepubertal factors that make children more likely to attempt suicide during adolescence. Suicidal behaviors or preoccupations before puberty increased the risk that a child would try again in adolescence. Children in their sample who attempted suicide before puberty were six times more likely than other children to try again. Youngsters who thought about suicide were also at somewhat elevated risk when they became teenagers. Mood disorders in childhood were associated with a fivefold relative risk of committing suicide as an adolescent, and poor social adjustment in childhood with a fourfold relative risk. Thus, some adolescent suicide attempters appear to have begun experiencing depression and poor relationships with others while still in childhood.

Shaffer's and Pfeffer's work suggests that the best way to prevent child and adolescent suicide is to focus on identifying and treating children who are at risk. Although suicide may be a rare outcome of mood disorders, poor social adjustment, substance abuse, antisocial personality, suicidal ideation or family history of suicide, young people who suffer from any of these problems need quick intervention.

Leah Wallach is a freelance writer who is working on her dissertation in clinical psychology at SUNY Buffalo.

Suicide rates soar in mid-teens

Suicide among prepubertal children is rare. In 1992 in the entire country, only 10 children under the age of 10 committed suicide.

The rates go up only slightly in early puberty. The 1992 suicide rate among children 10 to 14 was 1.7 per 100,000, with boys and girls committing suicide at the same rates.

But around age 15, the rate of suicide rises sharply, and far more dramatically for boys. Among teenagers 15 to 19, the rate is 10.6 per 100,000. Boys in this age group kill themselves nearly 3.6 times as often as girls.

The suicide rate continues to rise into early adulthood before stabilizing at about 15 per 100,000 adults between ages 20 and 24.

Not only is the suicide rate disproportionately high among young men ages 15 to 24, it has been increasing — threefold over the last 20 years. Initially, the increase was among white boys only, but beginning in 1985 the rate of suicides among black teenage boys began rising rapidly and steadily. The rate among white males stabilized around 1992, while the rate among blacks continues to rise. By contrast, during the last 20 years, suicide rates remained constant among teenage girls of all backgrounds.

Researchers identify rare syndrome

Researchers at Ohio State University in Columbus have developed a way to help physicians diagnose a devastating, uncommon and hard-to-diagnose childhood malady. Cyclic vomiting syndrome (CVS), which was first reported in 1882, is a disorder characterized by recurrent, prolonged attacks of severe nausea and vomiting with no apparent cause.

In a study of children and teens treated for recurrent vomiting at Children's Hospital in Columbus, scientists found that young people with CVS can be clearly distinguished from those with recurrent vomiting. Results show that kids with CVS vomit four or more times per hour but have nine or fewer vomiting episodes per month. Kids who vomit chronically can have as many as 30 vomiting episodes per month but typically vomit only once an hour. For more information, contact B.U.K. Li at Ohio State University, (614) 722-3450.

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WHAT'S NEW IN RESEARCH

Youth self-report tool proves useful

A new youth self-report scale screens fourth- through 12th-graders for a range of problems, including psychopathology, psychosocial difficulties and risk-taking behavior. Not only does the Classroom Screening Scale (CLASS) effectively detect at-risk youth, it may also be a better indicator of mood disturbances and withdrawal than its parent-report equivalent, according to two studies presented at the American Psychological Association conference

CLASS, an abbreviated form of the Personality Inventory for Youth (PIY), is a brief classroom survey that can be completed in less than 15 minutes. It was designed to detect regular education students who likely have significant emotional or behavioral problems.

In one study, Leslie Ziegenhorn of Wayne State University in Detroit and David Lachar of the University of Texas in Houston and their colleagues tried the survey on 233 adolescents at a metropolitan Detroit high school. The results were compared to the students' scores on these other measures of risk: the Beck Hopelessness Scale, Reynolds Adolescent Depression Scale, Conflict Behavior Questionnaire-20, Personal Experience Screening Questionnaire and Young Driver Attitude Scale.

CLASS proved to be especially sensitive in detecting depression, psychosis, conduct disorder and school-related problems. It was moderately sensitive to drug abuse, cigarette smoking, violence and family conflict.

Although the student suggests that the test is limited in detecting problems associated with anxiety, substance abuse, risky sexual behavior and motor vehicle safety, CLASS is one of the few ways to screen for such a broad scope of problems.

Lachar and another colleague, Nancy Howells Wrobel of the University of Michigan in Dearbon, compared the child self-report CLASS to the parent-report Adjustment Scale (ADJ) from the Personality Inventory for Children. (PIC). They found that children's and parents' reports may complement each other. For those children whose self-reports indicated adjustment problems, parents noted problems in a variety of areas.

The 111 children in this study were in fourth through sixth grade classrooms at three Midwestern public elementary schools. The students, who ranged in age from 9 to 13, were more likely to report mood disturbances, such as depression and withdrawal, than their parents, while the parents were more sensitive to overt behavioral problems than the children. Parents also were not likely to describe children who self-identified as having somatic problems, cognitive dysfunction or hyperactivity. The researchers theorized that parents may be unaware of internalizing symptoms such as somatic problems, and that children may be less likely than parents to report symptoms — such as impulsivity — that cause distress to adults.

The study suggests that CLASS may be helpful in school settings to identify children with behaviorally subtle problems, particularly when parents' reports are unavailable.

"Personality Inventory for Youth: Screening for high-risk adolescents," Leslie Ziegenhorn, et al. Reprints: Leslie Ziegenhorn, Department of Psychology, Wayne State University, Detroit, MI 48202.

"Utility of self- and parent-report in screening elementary students," Nancy Howells Wrobel and David Lachar. Reprints: David Lachar, Department of Psychiatry and Behavioral Sciences, University of Texas Medical School, Houston, TX.

Adults with ADHD may pass disorder to their children

Now that adult attention-deficit hyperactivity disorder (ADHD) is starting to get attention, a new study shows that it may have stronger familial etiological risk factors than its pediatric form. More than half of the 84 children of adults with clinical diagnoses of childhood-onset ADHD themselves met criteria for the disorder. This rate is significantly higher than the previously reported rate of ADHD siblings of ADHD children. Of the 48 ADHD children of ADHD parents, three-quarters had been treated for the disorder. The study also confirms the validity of the adult diagnosis of ADHD.

"Risk for ADHD in children of parents with childhood-onset ADHD," J. Biederman, et al., presented at the American Academy of Child and Adolescent Psychiatry. Reprints: J. Biederman, Massachusetts General Hospital, ACC 725, 15 Parkman St., Boston, MA 02114.

Pregnant teens may be at risk for suicide attempts

While pregnancy itself may not cause suicidal behavior among urban minority adolescents, it remains a serious concern. Half of the 46 urban teens who came to a psychiatric emergency room after a suicide attempt were pregnant, according to a recent study. The caretakers of both pregnant teens and those who were not pregnant said they had significant behavioral difficulties. Interestingly, though, the pregnant teens did not indicate any clinically significant behavioral problems, while the non-pregnant teens evidenced significant behavioral problems.

"Suicide attempts and pregnancy in minority urban adolescents," A.D. Dingle et al., presented at the American Academy of Child and Adolescent Psychiatry. Reprints: A.D. Dingle, Emory University School of Medicine, Department of Psychiatry, Grady Memorial Hospital, 80 Butler St. SE, Atlanta, GA 30335.

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READERS' EXCHANGE

Praise reward and pass the ammunition

In our February issue we ran a commentary entitled "The risk of rewards," by Alfie Kohn, author of *Punished by Rewards*. The Kohn View, not loudly applauded by parents, educators, and behavior modification specialists whose stock in trade is the dispensing of rewards or reinforcements for good (desired) behavior, is that the systematic use of incentives for "good" behavior reduces the likelihood that people will "do good" for intrinsic motivational reasons. We put the Kohn piece out on an e-mail behavior-analysis network, and invited responses, but did not anticipate the resulting firestorm of 50 replies! Dialogues occurred, some heated, most thought-provoking. Some eye-catchers:

I have been shocked to hear of the hidden risks of rewards! This is dreadful! Someone should tell the airlines to immediately halt their frequent flyer programs, because these will inevitably undermine the intrinsic value of traveling by airplane ... Also, someone better tell the Governor, so that the state's lottery program can be disbanded — otherwise intrinsic interest in betting will be eliminated.

— Bruce A. Thyer

... we need to get these dam Coke machines to stop undermining the intrinsic pleasure of coin dropping. The ones here in Nevada give you a Coke nearly every time you put money in.

— Kelly Wilson

... I have requested the State to shred and then torch my paychecks.

— J. Michael Faragher

Parents want their children to learn, especially reading, writing, and arithmetic. They want them to do well and go far in school. But if you ask students what the motivational system is for doing the work, they describe slavery. If you ask educators what the reason is for the lack of some work-renumeration system, they say that education depends on intrinsic motivation and intrinsic rewards. Kids are supposed to want to learn. Too many professionals, like Kohn, really think that kids should be "self-motivated." This condemns large numbers of people to being uneducated!

— Michael L. Commons

How could it possibly be harmful to arrange a relationship between behavior and consequences? The only alternative is to make the relationship between what one does and what happens utterly capricious, and that would be very difficult to do, even if someone were inclined to do so. Often in the classroom, rewards are delivered non-contingently, and this can have harmful effects.

— Christopher Newland

Alfie Kohn's criticism of "rewards" is fully deserved. Behavior analysts have failed to carry out needed research on the reinforcers and aversors available in the classroom. Behavior analysts should be able to specify in behavioral terms "engaging curricula," "a safe, caring community," "discover," "create," and the conditions under which the "choice" of learning Latin, rather than of learning how to cheat on a test, occurs. These warm, fuzzy terms should be a challenge to behavior analysts, who should be able to construe them into a clearly stated set of procedures ...

— William S. Verplanck

Alfie Kohn's position on the potentially damaging effects of rewards confuses the use of tangible rewards with the use of individualized reinforcing consequences. The consequences that he suggests (an engaging curriculum, opportunities to discover and create, and choices in learning) are, indeed, reinforcing for many children, but not for all. For those who are not responsive ..., more immediate and concrete consequences are desirable. ... Hundreds of studies demonstrate the value of individualized reinforcers (including those that Mr. Kohn suggests) for children and adults in many settings. Kohn seems to disapprove of praise. The only consequences that he seems to like are those inherent in the task. He thinks we should all work for the joy of working (or learn for the joy of learning).

— J. Gregory Olley

Dear Dr. Olley: Kohn argues that reinforcers simply don't work. The best retort to Kohn would be the presentation of incontrovertible evidence that indeed reinforcements do work with children, and that one can get "valued" behaviors from them based on measured presentations of response-contingent rewards.

— Lewis P. Lipsitt

Such evidence is found in: Loveland, K.K. & Olley, J.G. The effect of external reward on interest and quality of task performance in children of high and low intrinsic motivation. *Child Development*, 1979, 50, 1207-1210.

— J. Gregory Olley

In "The risk of rewards," values are said to grow as if it is a thing inside of us. Ironically, the study of values is the study of reinforcers.

— Yoshito Kawahara

The rewards motivating Kohn's behavior are all too obvious!

— Paul K. Brandon

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COMMENTARY

Children who lack conscience may become shameless adults

By Lewis P. Lipsitt, PhD, Editor

A few years ago, a respected middle-aged lawyer allegedly molested a teenager of the same sex while at a convention of juvenile court judges. Adults who engage in such behavior were once children, but their signals of distress as youngsters are often missed. They somehow manage to move on academically and professionally to respected positions, only to capitalize upon their authority and other adult privileges that allow them to cause harm to other persons. Plainly and simply, and often because of inadequate parenting and community resources, they can easily slip through unnoticed or without appropriate attention.

It happens all the time. A priest gets arrested for homosexual encounters with a youthful parishioner. A school principal is convicted of arson. A psychotherapist unduly influences and seduces a client. And a college president is fired for making obscene telephone calls.

The problems that children and adolescents have in growing up can become the problems that people have as adults. Often the victims of circumstances beyond their control and ours, they may have had abusive parents, for example. They may, as adolescents, find themselves with ambitions they don't know how to fulfill, or with impulses, cravings, and fantasies that seem scary and which they are not inclined to reveal to anyone else. Another of many problem scenarios could be that they couldn't get anybody to listen to them about their sexual identities and confusions. We forget that the children and adolescents whose problems we address, and whom those in service professions are trying to help, often grow up to be ostensibly OK, but aren't really OK.

Children and adolescents with problems grow up to be adults, and they are often burdened with the same problems they had years before, especially if they had no help. They often become judges, doctors, teachers and scout leaders. As they become mature looking, it is presumed by others that they are indeed "mature." But looks deceive. The mental status of that mature looking person may well be riding on the cerebrum of a kid that never got beyond 12-year-old relationships with other people.

Frighteningly, the courts are today swarming with cases in which individuals of questionable conscience have become viciously assaultive toward others, often quite surprisingly as judged by the reports of friends and other close associates. These friends can be heard to say such things as "Why, he's the last person I would have thought would do such a thing."

By the same token, some of the aggressions of smart adults can take subtle form. A business scion turns out to have been robbing his ten best friends. A respected CEO ruins the careers of a half dozen of his hand-picked deputies, suiting only his needs as he conspires to keep his power.

People with conduct disorders as adults can be ingratiating, they can be clever in attracting the trust of others, and their personality aberrations may go unnoticed for the first decades of their lives. What is most surprising about them is the surprise we have when they are revealed.

Only recently has serious research attention been paid to such disorders, their origins, and their earliest manifestations. Increasing knowledge about how humans get this way should promote early detection. Effective interventions are also ripe for discovery.

The Brown University Child and Adolescent Behavior Letter

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Inhalants: A Dangerous Experiment

You may have heard your friends talking in a new way about gasoline, felt tipped pens, deodorants and nail polish remover — as drugs. The word is out: Inhaling, sniffing or, as it's called on the street, "huffing" chemical substances is an easy, cheap and legal way to get a quick high.

But before you rush off to experiment, there are things you need to know. Inhalants can be extremely dangerous. The chemicals they contain can block the nasal passages and coat the lungs, and the solvents have many long-term effects. These include:

- Frequent nosebleeds;
- Sores in the nose, mouth and throat;
- Pallor and weight loss;
- Depression, irritability, paranoia and hostility;
- Liver and kidney damage;
- Bone marrow abnormalities; and
- Mental confusion and fatigue, which may lead to tremors and brain damage.

While under the influence, users also experience drooling, sneezing, nausea, coughing, hypersensitivity and loss of coordination. Repeated inhaling can result in seizures, unconsciousness and death from heart failure, suffocation or accidents. Deep sniffing can kill even first-time users.

Inhalants give a quick high that may include lightheadedness, exhilaration and sometimes hallucinations. Some users feel empowered by them, which leads them to dangerous behavior. The first inhalation often wears off in just a few minutes, causing users to sniff repeatedly to maintain a high. This makes the negative side effects more likely.

Regular use raises tolerance, which means that greater amounts are needed to achieve the same effects. You are unlikely to become physically addicted to inhalants, experiencing full-blown withdrawal symptoms when you stop inhaling, but you may become psychologically dependent. This means you experience strong cravings and have difficulty quitting.

The high isn't worth the risk — inhalants may be cheap and legal, but they are as dangerous as other drugs.

Source: Dwight B. Heath, Ph.D., is a Professor of Anthropology at Brown University

The Brown University Child and Adolescent Behavior Letter

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

SPECIAL REPORT: THE TRAGEDY OF EXCLUSION

Vol. 11, No. 5 May 1995

Special Report 7

- Veteran teacher Vivian Paley talks about the Golden Rule — and why it's crucially important to teach it to children while they're young.

First person 3

- A cartoonist/writer describes his harrowing memories of being tormented by schoolmates as the only Jewish boy in his class.

Research 4

- This HIV risk-reduction program worked, but not for young men who were anxious and depressed.
- Teens don't seem to get why stealing is wrong.
- Autistic children are often depressed.

Keep Your Eye On 6

- risky behavior. Almost three-quarters of all deaths among youth are from these four causes — and they're all preventable.
- educational screenings. Students will be learning about the Holocaust by watching *Schindler's List* in their classrooms.
- danger of inhalants. The war on drugs has ignored the prevalence and real dangers of kids sniffing common household products.
- case management. Teen girls did better in school with case management than they did with an offer of cash.
- baby walkers. They're not as sweet as they look.

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- Can't we teach children the flip side of human aggressiveness: that the greater peril comes from sacrificing another's well-being?

PB 025074

Studies of prejudice prompt researcher to call for character education

Prejudice, like just about everything else human, changes across the life span, and that has implications for the classroom, especially in schools that adopt character education.

In the schools

Although researchers have been studying children's prejudice earnestly since the civil rights movement, some of their work may be invalidated by an inflexible definition of prejudice, according to Florence H. Davidson, EdD, who spent 25 years testing developmental hypotheses about children's attitudes.

"The research shows much more prejudice at young ages because we're scoring prejudice as if it were the same thing all through life, whereas it's just superficially the same," says Davidson, a former research fellow at Harvard Graduate School of Education. "Young children react to superficial characteristics that are foreign to them, like black skin or hair they don't like," which is qualitatively different from the deeper prejudices adults are more likely to harbor.

"Of course, there are different susceptibilities, but research shows a lot more cognitive influence than the public is aware of."

Davidson conducted a cross-sectional study of 154 fifth-graders in several city and suburban schools around Boston to compare chil-

(turn to 7)

Children go through stages of teasing

Anyone who's ever been to a school playground during recess knows how mean children can be.

Behavior

But the concept of "mean" changes as children get older, says a child psychiatrist, and by adolescence teasing turns into more symbolic forms that can be rejected by the victim.

First-graders, for the most part, engage in physically hurtful teasing, such as tying a classmate's shoelaces together, according to Theodore R. Warm, MD, who asked 250 children and adolescents about teasing. By sixth grade, hurtful teasing is replaced by what Warm calls mean teasing — calling a burn victim ugly, for example. But as young people move into adolescence, their teasing gets more sophisticated and symbolic.

"In first grade, actions speak louder than words. You can't really use verbal teasing when you're that young," Warm explains. "By sixth grade, words are as good as actions." These children take words very concretely: it doesn't make any difference whether the victim of teasing is disfigured or not. The words are taken as much as reality."

Words as symbols

Adolescents discover the truth of the adage "Sticks and stones may break my bones, but words will never hurt me." By 11th grade, sym-

(turn to 2)

This month's client handout: Inhalants — a dangerous experiment

Teasing

from page 1

bolic teasing accounts for about 80 percent of the teasing. "They start to realize that the words are only symbols of harassment, and if you don't accept that symbol as having authenticity, you can then overlook it and not get upset by it," says Warm, a child and adolescent psychiatrist at Rainbow Babies and Children's Hospital in Cleveland, OH.

But Warm's graphs resisted neat grade divisions into hurtful, mean and symbolic teasing. About a fifth of adolescents' teasing was the hurtful or mean stuff of first-graders, and, more surprisingly, first- through sixth-graders engaged in the higher-level, symbolic teasing almost half the time.

"If symbolic teasing comes with adolescence and some abstract thinking in Piagetian ways of looking at things, you have to say, 'How come?'" Warm says about his findings. "My data do not explain that, but my guess is there's a copying of older-type teasing. The younger children copy verbal teasing, but they don't really understand it themselves."

Warm gave his six-question questionnaire to students in first, third, sixth, eighth and 11th grade in two Cleveland school systems, one in the inner-city and one in the suburbs. Warm asked the children:

1. Describe the best teasing that you like to do.
2. Why do you like to do it?
3. Does the person you are teasing like it?
4. Describe the worst teasing you hate to have done to you.
5. What do you do when you're teased?
6. How can you keep teasing from bothering you?

Warm used the kids' answers to the first and fourth questions to categorize types of teasing. Interestingly, the graphs of these questions were almost identical. "What they like to do to others is what they hate to have done to themselves," he explains.

Questions 2 and 3 revealed the teaser's motive, which Warm subdivided into a playful, friendly intent, and the sadistic pleasure of making someone else miserable. The overwhelming majority — about 80 percent — reported a sadistic motive, and that stayed almost the same through first, third, sixth and eighth grades, until it dropped off a little (but not much) in 11th grade. "The rest of them were of friendly intent: 'It was kind of fun, and we're just having a good time,'" Warm says. "But the idea that you're enjoying somebody else's misery was the predominant motive."

Coping with teasing

The young people in Warm's study, especially as they got older, usually coped with being teased on their own. About a fourth of the first-graders said they would tell their teacher or parent, but by third grade, 90 percent say they handle teasing themselves. An overwhelming 95 percent of sixth-graders say the same thing.

"That's what they say; what they do may be something else," says Warm, pointing out that one of the shortcomings of his study is its self-report design.

Students who handled teasing by themselves either responded by retaliating against or ignoring the teaser. Retaliation was a little — but not much — higher than ignoring.

Teasing is an inevitable part of growing up, and it seems that kids are adept at handling it on their own, but when teasing gets out of hand, it can lead to problems. Warm says that it is sometimes appropriate for adults to intervene, particularly among prepubertal children. "When other kids use a cruel, symbolic teasing, an older person would be able to see through it, but the latency kids are stuck in a concrete operation and their cognitive capacities haven't matured enough so that they can understand the symbolism of it," Warm says. "The word is the same thing as having it. If you call somebody fat, it's the same as being fat. I think all of us who do clinical work — or have our own kids — know how miserable kids can be."

For more information, contact Theodore R. Warm, MD, Department of Pediatrics, Rainbow Babies and Children's Hospital, 11100 Euclid Ave., Cleveland, OH 44107.

Announcements

Landmark College, the only accredited college in the country exclusively for students with dyslexia, attention-deficit disorder or specific learning disabilities, will host a conference on developments in neuropsychology, education and medicine in the field of learning disabilities. The conference, "Opening Our Gifts," will be held Sept. 21-23 at the Putney, VT, college. The registration deadline is July 30.

Landmark is gearing up for its summer session to help learning-disabled students develop college skills. In addition to study techniques, students will learn composition, organization and comprehension skills. During the academic year, Landmark offers credit courses leading to an associate of arts degree in general studies. The average class size is seven students, and the student-to-teacher ratio is about 2.5:1. Landmark students learn about their own and other learning disabilities and learning styles. **Contact:** Dianne D. Wood, Landmark College, RR 1 Box 1000, Putney, VT 05346; (802) 387-6738.

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FIRST PERSON

Remembering Holocaust's echoes in small-town America

By Lou Golden, MFA

Editor's note: We asked Lou Golden, an Oregon writer and cartoonist, to share his memories of being mercilessly harassed by schoolmates as a young Jewish boy in Pennsylvania Dutch country just before World War II. This is excerpted from a book he is working on.

I remember my growing dread each morning as the tiny pale headlights of the school bus emerged from the gloomy horizon, signaling its inexorable arrival. When it stopped before me on the country road and its doors clattered open, I felt as if I were stepping into hell.

The aisle of the bus had become a gauntlet of shame. Shame because my schoolmates refused to share a seat with me and stipulated that "Jews sit in the back with the girls." Shame because I obeyed their command day after day without protest, tripping over their extended legs and silently taking anti-Semitic pejoratives and kicks in the shins. Shame because if a boy invited me to sit next to him, I would often fall for it out of desperation until he suddenly shoved me and my books into the aisle, refusing to sit next to a "filthy Jew."

If I tried to retrieve my books from under the seats, they were kicked out of reach until we arrived at school. My schoolmates would take them off the bus and drop them around the schoolyard. After months of this treatment, I was deeply ashamed of myself and almost everything about me.

My family had recently moved from North Philadelphia to bucolic New Britain, a Doylestown suburb, and my culture shock began on the first day of school when our teacher announced that I might remain silent and seated while the rest of the children stood to recite the Lord's Prayer.

At recess I found myself surrounded by schoolmates who wanted to know why I was excused from prayer. "Do you belong to a church? Don't you believe in Jesus? In God?" A boy grabbed my collar; another, my arms. "Are you a Jew?" "You are a Jew, ain't ya?" "Christ killer!" "Pig!" "Swinehund!" The circle of young faces brightened as my Jewish identity, and my vulnerability, dawned on them.

I was punched and pushed back and forth from one grinning child to the other. Then several boys, twisting my neck like a rodeo calf while another one bent my arm behind my back, dragged me to the floor as other children, cheering with delight, began to kick me.

I can still see my gray-haired teacher calmly puffing his pipe and looking down at me as I lay on my back, my chest and arms straddled by a strong Mennonite farm boy, who, holding a fistful of my hair, repeatedly pounded my head on the hardwood floor.

I can still hear my brutalizer asking between head bangings, "Hey, Jewboy! Do ya give up?" My answer was always no. Refusing to surrender during beatings constituted my only resistance — a precious bit of me that would not be humiliated nor enslaved by violence or fear.

But gradually, I did surrender the rest of me — bit by bit, slavishly, with each miserable little compromise, with every pathetic, futile, frustrating attempt to buy a measure of acceptance and peace or at least to end the violent subjugation with pieces of my identity, integrity and self-respect.

And it wasn't just me they terrorized. I remember my schoolmates lining along the road as my mother's Plymouth passed, arms outstretched in a Nazi salute, yelling, "Heil Hitler!"

"Some silly people are like that. They just don't like us," my mother shrugged. "Be patient, honeybun. It will pass."

My parents' advice hadn't changed much since the day, three years before, when I came home from first grade, having bloodied the nose of the class bully, and asked them what "dirty Jew" meant. "Don't get into fights!" my mother said. "Ignore them. A Jewish boy shouldn't fight!" "I can't stand to see you get hurt," my father said.

I was being taught a debilitating paradox: I was not expected to fight anti-Semitism because I was a Jew.

When I was 6, I was holding my mother's hand in the principal's office when his secretary blurted, "No wonder Hitler wants to kill all of you," because mother had insisted on discussing my left-handedness with the principal.

Although the principal eventually said I would no longer be forced to write with my right hand, I wondered if he was thinking murderous thoughts about Jews too.

One Sunday afternoon, I heard a radio broadcast of a speech by Adolf Hitler. The detail that impressed me most was the deep obeisance given the Fuhrer by the English-speaking announcers. It did not seem to me that it would pass.

Gazing at a beautiful Pennsylvania sunrise the next morning, my mother quietly revealed the existence of a family suicide plan "if Hitler conquers the world and comes here." I was horrified and frustrated. I wanted a fight-or-flight plan. It had yet to be named, and though I didn't know how I would do it, I wanted to survive the Holocaust.

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HIV intervention benefits less distressed youths

A half to three-quarters of a group of young gay and bisexual men who took part in an intensive HIV intervention program were engaging in less risky sex a year later. But the program worked better for youths with low levels of anxiety, depression and substance use and high self-esteem, according to a just-published longitudinal study. These predictors were stronger than the young men's beliefs about AIDS and its prevention, their self-efficacy and self-control and support from friends and partners. The 136 14- to 19-year-olds were recruited at a community-based agency for homosexual youths. They were predominantly Hispanic and black. The young men took part in a 20-session HIV/AIDS risk reduction intervention program, meeting in small groups two to three days a week to learn the facts about HIV, coping in high-risk situations, locating health care resources and overcoming individual barriers to safer sex. They also discussed disclosing their homosexuality to others and prejudice against homosexuals as potential mediators of safer sex attitudes. The young men were re-assessed three, six and 12 months later and classified according to patterns of anal and oral sexual acts: protected, improved, relapse, variable and unprotected. Over a year, about three-fourths of youths either improved or engaged in protected anal sexual acts; half improved or engaged in protected oral sexual acts. Young men who relapsed into unprotected sex were more anxious and depressed and consumed alcohol more frequently than youths who practiced protected sex. Self-esteem, which predicted healthier behavior for anal sex acts, was not significantly associated with oral sex acts. The researchers recommend that HIV interventions address seemingly non-related issues, particularly emotional distress among youth.

"Predicting patterns of sexual acts among homosexual and bisexual youths," Mary Jane Rotheram-Borus, et al., *American Journal of Psychiatry*, 152(4):588-595, 1995. For reprints, contact Mary Jane Rotheram-Borus, PhD, Health Risk Reduction Projects, UCLA Neuropsychiatric Institute, 10920 Wilshire Blvd., Suite 1103, Los Angeles, CA 90024.

Teens don't understand why it's not OK to steal

A new study measuring moral development in adolescents found that teens were deficient in understanding why they shouldn't steal. Researchers found that non-delinquent teens generally scored well on a test that measured their moral judgment concerning values such as telling the truth, keeping promises, saving a life and helping their parents. But the test showed that teens had relatively immature or self-serving reasons for why stealing is wrong. For example, they said that you shouldn't steal because you might get caught and punished. The study involved 163 non-delinquent teenagers from a suburban public school, 89 incarcerated male delinquents, and 71 incarcerated female delinquents. All of the teens completed the short form of the Socio-moral Reflection Measure, the investigators' test for measuring moral reasoning. As expected, delinquents showed evidence of lower moral reasoning than non-delinquents. This difference remained even after the delinquents' lower socioeconomic status and verbal intelligence were taken into account. Female non-delinquents showed the highest levels of moral reasoning, followed by male non-delinquents, female delinquents and then male delinquents. The fact that girls generally had a more developed sense of moral reasoning than boys is not surprising because girls also develop faster than boys in other cognitive areas, as well as physically. More than 90 percent of the teens — both delinquents and non-delinquents — rated the moral values discussed in the study as important, a finding the researchers called "a ray of hope." They recommend that moral education programs in schools emphasize respect for property.

"Patterns of developmental delay in moral judgment by male and female delinquents," Virginia Gregg, et al., *Merrill-Palmer Quarterly*, 40(4):538-553, 1994. For reprints, contact Virginia Gregg, MA, and John C. Gibbs, PhD, at the Psychology Department, The Ohio State University, 1885 Neil Ave., Columbus, OH 43210.

Depression can co-occur with autistic disorders

Depression often goes undiagnosed as a comorbid disorder in children with autism and other developmental problems, according to a recent study of young patients admitted to a child psychiatry unit. A group of 11 children — nine boys, two girls — with autism/pervasive developmental disorder (PDD) and depression were compared with an age- and sex-matched control group of patients with autism/PDD but no depression. All of the patients in the depressed group had arrived at the hospital with suicidal ideation, including one who was admitted after a suicide attempt. These children had had significantly more life events, such as bereavement, in the year before the onset of their depression. But the depressed and non-depressed groups did not differ in their family history of depression nor of developmental disorders. These findings suggest that clinicians should identify mood disorders in autistic children and other pervasive developmental disorders.

"Depression in children with autism/PDD presentation, family history and life events," M. Ghaziuddin, et al., presented at the American Academy of Child and Adolescent Psychiatry annual meeting. For reprints, contact M. Ghaziuddin, MD, at the University of Michigan Medical Center, TC Box 0390, 1500 E. Medical Center Drive, Ann Arbor, MI 48109.

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News Update

- Despite the diagnosis of 40,000 new cases of **HIV infection** every year in the United States, achieving lasting changes in risky sexual behavior is possible with tailored, credible and persistent HIV risk-reduction efforts, according to researchers at the University of California at San Francisco. (*Journal of the American Medical Association*, 273:1143-1148, 1995)
- Plastic mattresses do not cause **crib death**, and in fact, babies sleeping on fire- or waterproofed mattresses are less likely to die of sudden infant death syndrome (SIDS), researchers in England reported. Responding to a television report that linked crib death with toxic chemicals in fireproof baby mattresses, the researchers checked what kind of mattresses were slept on by more than 400 infants, including 93 SIDS victims. (*Lancet*)
- Medical students at Northwestern University are learning more about **alcohol-related birth defects**. The university's five-week curriculum on fetal alcohol syndrome (FAS) is being taught by an interdisciplinary team of experts who will encourage students to think about the pathology of FAS as identifiable, preventable and treatable.
- Two-thirds of 10- to 16-year-olds surveyed said they have three or more **television** sets in their homes, and half said they had TVs in their bedrooms. But three-quarters said if they had a choice between watching TV or spending time with their families, they'd opt for family time. (*Boston Globe*, April 6, 1995)
- Divorced dads in New Jersey may not have to pay **child support** after their children turn 18 if a bill passed by the state assembly is OK'd by the state senate. (*New York Times*, April 26)

At the Library

Summer camp is often the first time youngsters are away from home for a long period of time. The joys of making new friends, being outdoors and learning new skills are often overshadowed by the fear of being on their own and not knowing anybody. The following books relate first-time camp experiences and acknowledge the apprehension many children feel. These books can be found at most public libraries.

Pig Pig Goes to Camp by David McPhail, Dutton, 1987. Pig Pig always said no when his mom asked him if he wanted to go to overnight summer camp until the year he felt old enough and asked if he could go. A silly book about all the wonderful things he does at camp and the unusual friends (frogs) he makes. Ages 4-8. 1-800-526-0275

Arnie Goes to Camp by Nancy Carlson, Viking Kestrel, 1988. Arnie is every child in a first sleepover camp experience. He wasn't so sure he'd love camp even if his mother said he would. All the other kids seemed to know one another and all the camp songs from before. At the end of two weeks, arts and crafts, new games, campfires, nature hikes and new friends, Arnie wished summer camp could go on forever. Ages 4-8. 1-800-331-4624

Pinky and Rex Go to Camp by James Howe, Atheneum/ Macmillan, 1992. Because his best friend wants to go to camp, Pinky's parents think that he does too and sign him up. It's not that he's really afraid of what his little sister says about poison ivy, snakes, piranhas in the lake and counselors who turn into monsters at night and eat campers, but the idea of leaving home makes his stomach hurt. A book to be read to younger children or for new readers to read for themselves, ages 4-8. 1-800-223-2348

Barbara Goldberg, MLS, is a contributing editor to *All Kids Considered*, an independent parenting publication.

Speaking of Books

Kwanzaa and Me: A Teacher's Story
Vivian Gussin Paley
Cambridge, MA: Harvard Press
140 pages, $18.95 (hard), 1995
To order, call 1-800-448-2242

Vivian Paley, author also of *You Can't Say You Can't Play*, is a renowned teacher at the University of Chicago Laboratory Schools. She deals with outsidedness — the natural exclusionary quality of groups even when integrated education and multicultural classrooms are the order of the day. The book is about belongingness, and the Paley style is one of story-telling. Characters of the book are black teachers, minority parents, immigrant families, and the children associated with them. Paley travels among schools, surveying the effects of diversity in the classroom and the assessments of the children who experience the melting pot. It is through dialogue that Paley makes her best points — often the dialogue of others.

The Rhetorical Voice of Psychoanalysis
D.P. Spence
Cambridge, MA: Harvard Press
228 pages, $29.95 (hard), 1994
To order, call 1-800-448-2242

One of the most rigorous scholars of psychoanalysis, the theory and its practice, Spence worries that little progress has been made in psychoanalytic thinking for many decades. He regards the theory largely as a shared fantasy. Lacking in appropriate data, the theory cannot move ahead. Spence places psychoanalysis in the context of other sciences that have had great practical influence and efficacy.

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Keep Your Eye On

. . . risky behavior.

Risky behaviors that contribute to the leading causes of death, disease and social problems are often established in youth, according to a new study by the Centers for Disease Control and Prevention (CDC). According to the CDC's Youth Risk Behavior Surveillance System, 72 percent of all deaths among school-age youth and young adults are from four causes: motor vehicle crashes, other unintentional injuries, homicide and suicide. Many of the high school students surveyed for the study practice behaviors that may increase the likelihood of their deaths from these four causes. For a copy of the study, contact CDC's Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Mailstop K-33, 4770 Buford Highway, NE, Atlanta, GA 30341-3724, (404) 488-5330.

. . . educational screenings.

Students across the country will get to watch *Schindler's List*, the Academy Award-winning film on the Holocaust, in their classes. Director Steven Spielberg's production company, which was at first reluctant to show the film outside of movie theaters, has provided 37,000 copies of the video for use in high schools across the country, complete with curriculum guides for teachers. The idea of classroom viewing was pushed by retired social worker Albert Goldstein, who said it would allow teachers to pause the video at appropriate points and encourage discussion of the on-screen events.

. . . danger of inhalants.

The Partnership for a Drug-Free America recently announced an advertising campaign to educate parents about the risk of inhalant abuse and encourage them to talk with their children about it. Nearly one in five teenagers has sniffed common household products, such as glues, gases and sprays, to get a quick and easy high. But while many parents, teachers and anti-drug campaigns educate young people against alcohol, marijuana and other drugs, the message of the danger of inhalants gets lost, the organization said. (Associated Press)

. . . case management.

Case management helped teenage girls improve their grades and school attendance more than did an offer of $50 a month, according to a study published by the National Association of Social Workers (NASW). The case management approach — in which a team including a social worker, a teacher or school staff, the student and her parent or parents worked jointly to solve problems — also boosted the girls' self-esteem, while the cash incentives offer had the opposite effect. Although cash payments may have provided initial motivation, case management may have been more effective in giving the girls the skills and support needed to succeed in school, the study suggested. (*Social Work Research*, December 1994)

... baby walkers.

Baby walkers should be banned, and existing walkers should be destroyed to reduce infant injuries, says the American Academy of Pediatrics (AAP). Proponents of walkers tout them as devices that provide exercise, promote walking and keep babies quiet and happy. The AAP says there is no scientific data to support these claims. In fact, in 1993, 25,000 children between the ages of 5 and 15 months were treated in hospital emergency departments for walker-related injuries at a cost of $90 million. Injuries are overwhelmingly caused by falls, and stairs are involved in 75 to 80 percent of the cases. (*Pediatrics*, May, 1995)

Resources

Newsletter launched

National Fragile X Advocate's inaugural issue went to 1,500 subscribers. The new newsletter combines professional information and inspiration to advocate for improved services for children and adults with fragile X syndrome. **Cost**: $36 a year (six issues). **Contact**: Avanta Publishing Co., PO Box 17023, Chapel Hill, NC 27516; (919) 967-0322.

Teen offenders talk

A conflict resolution film uses graphic interviews with teenage offenders and their victims to offer students a new way to look at conflict, resolution, responsibility and consequences. The 35-minute film, Just Because, is available in VHS format. **Cost**: $295. **Contact**: Pyramid Film & Video, PO Box 1048, Santa Monica, CA 90406-1048; 1-800-421-2304.

Helping grieving teens

A video called *A Teen's View of Grief* shows bereavement counselors how to better help 12- to 19-year-olds. The 40-minute video covers adolescent developmental tasks complicated by grief, the adolescent's mourning needs and signs that a teen may need extra help. **Cost**: $1.50. **Contact**: Center for Loss & Life Transition, 3735 Broken Bow Road, Fort Collins, CO 80526; (970) 226-6050.

At-risk youths studied

A new monograph examines the causes, problems and treatment of at-risk behavior. The monograph includes arguments for and against incarceration, as well as some alternative program ideas. **Cost**: $7. **Contact**: Dr. Anthony Richards, Youth Research Unit, Division of Leisure Studies, Dalhousie University, Halifax, NS, Canada B3H 3J5; (902) 494-1160.

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Prejudice

from page 1

dren's prejudices with their stages of moral judgment. She found them to be inversely correlated. "Kids who were able to think fairly were less prejudiced," explains Davidson, who describes her work in the newly published book *Changing Childhood Prejudice: The Caring Work of the Schools* (Greenwood, Westport, CT), which she co-wrote with her daughter, Miriam.

Davidson invented a game — an original idea in 1970 — to elicit children's spontaneous comments about their prejudices. Each playing piece of the Parchesi-like game represented one of eight American ethnic groups: black, Indian, Irish, Italian, Jewish, Mexican, Oriental and Puerto Rican. The goal was to overcome unspecified social obstacles and reach home, having become a complete American. Each player had to make a comment about one of the ethnic groups whenever a throw of the dice landed him or her on a certain space.

"In the heat of the game, they wanted to win and they'd say any old thing and in the process reveal their prejudices."

Davidson found that youngsters who were at lower moral stages gave the most negative comments about the various ethnic groups. And while prejudiced remarks decreased 10 to 14 percent between the ages of 7 and 13, the inverse correlation between moral stage and prejudice remained.

And it stayed the same when the effects of age and intelligence were accounted for. Other studies have found that, contrary to popular belief, there is a low correlation between children's prejudice and that of their parents. In fact, young children are generally *more* prejudiced than their parents.

Davidson also refutes the idea that prejudice is based on lack of exposure to other ethnic groups. "That was the reasoning behind busing, but they found the opposite: The more exposure they got, the more they hated each other."

But people can be trained to think and act in more sophisticated ways, says Davidson. Hence, the subtitle of her book: "The Caring Work of the Schools." A self-declared liberation psychologist, Davidson thinks that moral and character education should be taught in school. "Schools have to become deliberately caring or aware of the importance that human relationships are just as important as academics," she says.

For younger children, it is best to start with feelings and motivation and then add the intellectual component as the child is developmentally ready, she says. Middle school students need guidance from a mentor, whether a parent, teacher or other close relationship. High school students need help in connecting what they learn and how they live. Directing their idealism is the goal of the school for this age group, says Davidson, who followed 22 of her original study subjects through the rest of their public school years.

Prejudicial thoughts are a universal human experience because we base our identity on our differences from others. "What we have to do is become more moral so we don't go around expressing them."

That doesn't guarantee that we won't still think them. "We'll always react more warmly toward people who are like us. We can't change that, so we have to change how we behave," she says

To order the Davidsons' book, *Changing Childhood Prejudice: The Caring Work of the Schools*, call (203) 226-3571.

Setting down the Golden Rule

Although veteran teacher Vivian Gussin Paley has, by her own admission, never in her life used the words "character education," she values any approach that puts the Golden Rule into practice.

"The number one issue is that you do not do to someone else what you would not have them do to you," says Paley, who teaches kindergarten at the University of Chicago Laboratory Schools. "The fact is that we do permit some children to be rejected."

It's not a difficult rule to institute, says Paley, author of *You Can't Say You Can't Play* (Harvard, Cambridge, MA, 1992). "The acceptance of the rule at a young age is as easy as the acceptance of its opposite," she says. "Any group of children — or adults — will find a reason to lift some people up and put some people down. The question is: Must it be so?"

The answer is no in Paley's classroom and in a growing number of others across the country. "We better begin training children to grow up in a democratic society," she says. "Whatever other attempts at character modification we make, none of them will do any good unless our classrooms carry forth, without ambivalence, the general notion that the classroom, playground, gym, are owned by everyone. And the younger the children are, the more they will accept it as the way of public life."

Teachers have to do more than model appropriate behavior. "We have to set the moral landscape of the classroom," she says. "Children do not, generally speaking, behave in prejudiced ways. They quickly get the feeling that it's allowed. You tell them it's not allowed, and it's a great relief because they can, without worrying, include everybody and know that they too will be included."

Vivian Paley's newest book, *Kwanzaa and Me: A Teacher's Story*, is reviewed on page 5.

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COMMENTARY

Us and them

Much of *The Brown University Child and Adolescent Behavior Letter* this month is devoted to what might be called, in terribly technical terms, "exclusionary practices" of human beings. What we mean by that is people behaving meanly toward others, as if some humans have a greater right to life and the pursuit of happiness than others.

David A. Hamburg, who heads the Carnegie Corporation of New York, concluded his important president's report last year with the following poignant statement:

"There is little in our very long history as a species to prepare us for this world we have suddenly made. Perhaps we cannot cope with it — witness Bosnia and Rwanda. Still, it is not too late for a paradigm shift in our outlook toward human conflict. Perhaps it is something like learning that the earth is not flat. Such a shift in child development and education throughout the world might at long last make it possible for human groups to learn to live together in peace and mutual benefit."

The shift that Dr. Hamburg calls for may not be so wild a dream. After all, people do bond with one another, as in families. And people do form communities of families to protect one another, especially in times of crisis. Humans do rally around the stricken and the imperiled: Recent events in Oklahoma City demonstrate just how wonderfully willing humans are to broaden their attachments and extend their protective impulses to include even those they have never known.

Heroes and terrorists are context-defined, and are sometimes the same people, depending upon the angle of view. It is not easy for humans of any stripe to be tolerant of someone who may demean, denigrate, disenfranchise or demolish them. Why does it seem to require a crisis for humans to become benevolent toward the broader community, and behave protectively toward others?

Maybe the answer is in human development, in the psychobiological nature of bonding and attachment, and the seemingly inherent characteristic of humankind to choose up sides between *us and them, we and those, mine and his, friends and enemies, loved ones and strangers*. The fact is that, in normal human development, infants do come by the end of their first year to "choose up sides." They can, and do, differentiate familiar people from strangers. Indeed, it is good child-training to warn children at a young age, perhaps more so today than in generations past, that not everyone is their friend. There are real dangers out there, and it is only good parenthood to alert youngsters to the hazards of the world.

But mightn't we teach the other side of the coin at the same time? Can we not teach children, even as we protect them from victimization, that for them to become victimizers constitutes the greatest peril of all, specifically the sacrifice — physical or psychological — of the well-being of other people? And that destroying the life or safety of other people, through teasing, bullying, hitting or otherwise "putting them down," is as destructive to themselves as to their victims? That is the necessary paradigmatic shift we must strive for. Protecting other people saves one's selfhood, one's person. This is as much a bio-psycho-social verity as any observation about our inherent aggressive tendencies toward strangers.

Lewis P. Lipsitt, PhD, Editor

The Brown University Child and Adolescent Behavior Letter

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Trade Center bombing holds lessons for aftermath of Oklahoma tragedy

By Juliet M. Vogel, PhD, and Harold S. Koplewicz, MD

Editor's note: Drs. Vogel and Koplewicz studied children who

Research

were exposed to the 1993 bombing of the World Trade Center. We asked them if any lessons could be extrapolated to the Oklahoma City bombing.

For children who are directly exposed to disasters, the most common symptoms include increases in:

- Fears related to the disaster (not of unrelated fears), such as fear of elevators in the children who were in the World Trade Center.
- Sleep difficulties, including problems getting to sleep, nightmares, or not wanting to sleep by oneself.
- Clingy behaviors and separation difficulties.
- Symptoms associated with post-traumatic stress disorder.

Post-traumatic stress disorder (PTSD) is diagnosed when a significant stressor leads to symptoms in each of three categories: intrusive re-experiencing of the trauma — which for children includes repeatedly acting out trauma-related themes in play; attempts to avoid reminders of the trauma or general emotional numbing; and increased

(turn to 2)

How can you tell which children need extra help coping with the bombing?

By James Garbarino, PhD

Not since the Gulf War in 1991

Clinical Issues

have we as a nation been so intensely exposed to a collective violent trauma. We are being challenged as researchers, clinicians and parents to examine our knowledge base about the way traumatic events are communicated to children. What do we know about the way children process information about such events? How can we help make the best of this experience?

First, we know that the more closely connected children are to the traumatic event, the more likely they are to be affected by it. This "distance" is a social as well as a physical matter. Those children who "see" themselves in the event are more likely to experience upset or even trauma. Knowing someone directly affected or even just seeing an uninterrupted line of connection may be enough to forge this bridge over which trauma may flow. Thus, we might worry particularly about children in day care centers in public buildings who understand the parallelism between their setting and the children in the Oklahoma City federal building.

Second, we know that children who are in acute or chronic crisis are more likely to piggyback their issues

(turn to 4)

This month's client handout: Respect your child's temperament

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Lessons

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arousal, with effects such as increased irritability and sleep disturbance. To make a PTSD diagnosis, there must be a specified number of symptoms in each of these categories, which must last for at least a month and must interfere with everyday functioning.

After disasters, children frequently show symptoms associated with PTSD, but only a small proportion meet the full criteria for a diagnosis. After a disaster involving severe life threat, up to 25 or 30 percent may meet criteria for PTSD.

Children's post-disaster symptoms are typically more extensive and more severe when they have been exposed to grotesque scenes of destruction, a strong threat to their lives, personal injury, or injury or death of family members. Some evidence suggests that pre-existing anxiety leads to more severe post-traumatic stress reactions.

Several studies have found substantial reduction in symptoms over a year after the disaster. For children who have had severe disaster exposure, however, symptoms may persist even after a year. The children with the strongest symptoms initially are the ones most likely to show strong persisting reactions. The limited available information suggests that even these youngsters eventually show good recovery.

Trade Center bombing

Our experience with children exposed to the bombing of the World Trade Center fits the pattern. The children in the building included kindergarten, second-, third- and fifth-grade children on class trips. Some were on the observation deck and were evacuated to the roof. They eventually exited the building by walking down more than 100 flights of stairs. Others were trapped in a dark elevator for several hours. The children in the elevator perceived the life threat: Several asked if they were going to die.

We studied 22 children from the oldest three age groups who had been in the World Trade Center and 27 community comparison youngsters. We obtained reports of children's fears and post-traumatic stress symptoms about three and nine months after the disaster.

The most exposed children as a group showed the highest level of PTSD symptoms and the community comparison group the lowest. Symptoms decreased over time, but even nine months after the disaster, the exposed groups as a whole still were showing a moderate level of symptoms.

Parents reported post-disaster onset of phobias and separation anxiety for some of the exposed children; by nine months post-disaster, the incidence of these disorders decreased. Within each group, there were strong individual differences in severity of response.

Worse in Oklahoma

The children directly exposed to the Oklahoma City bombing are likely to show more severe reactions than those exposed to the World Trade Center disaster. The children who had been in the Trade Center did not suffer physical injuries, nor were members of their family injured or killed. Children in Oklahoma City were more likely to be injured, exposed to grotesque scenes of destruction or bereaved.

If children's parents were in the building and survived, the children are at some risk of secondary symptoms in reaction to their parents' distress.

The children whose reactions to disasters have been least well-explored are preschool children. For 3- and 4-year-olds, we have some evidence that after severe traumas, they will show many of the same symptoms as older children. For them, post-traumatic play (repetitive play of disaster-related themes) often provides clues to their distress.

We have even less information about the reactions of minimally verbal young children, but we need to be careful not to minimize them. One of the most distressing aspects of the Oklahoma City bombing is the number of very young children who were affected, including youngsters who were in the nearby YMCA day care center. Colleagues have reported that these children indeed have been showing a significant degree of upset.

Other children

After the World Trade Center bombing, the community comparison group showed significant but relatively mild levels of post-traumatic stress symptoms. Although there was some decrease nine months later, many children still showed significant reactions. In Oklahoma City as well, there is likely to be some disaster-related distress in children who were exposed indirectly, through media coverage and general community reaction. Their distress may well be based in part on facing the reality that there are dangers from which adults cannot protect children.

There is a note of optimism. Mental health providers in the Oklahoma City area have been working with the children who were affected, and they are planning follow-up work. The level of persisting symptoms is likely to be lower for children who have had an opportunity to work through their concerns. Schools provide a useful site for interventions with children after community-wide disasters. Since the children with the highest initial distress typically are also the ones most at risk for persisting distress, it is useful to do an initial screening and then provide more intensive services to these children.

Juliet Vogel and Harold Koplewicz presented their findings at the annual meeting of the American Academy of Child and Adolescent Psychiatry. Vogel is also the co-author of two related articles in the *Journal of Clinical Child Psychology*, 22:464-498, 1993. For reprints of either one, write to her at the Division of Child and Adolescent Psychiatry at Schneider Children's Hospital, 269-01 76th Ave., New Hyde Park, NY 11040.

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SPECIAL REPORT

Hundreds call children's hotline to talk about bombing

More than 300 children and their parents and teachers across the country called a toll-free hotline to talk to mental health professionals about their fears and concerns in the wake of the Oklahoma City bombing. The hotline, which was headquartered at the University of South Dakota's Disaster Mental Health Institute, was sponsored by the American Psychological Association's Disaster Response Network, the American Red Cross and AT&T May 12-17.

"Because of the death of children in this bombing, it can trigger strong feelings of vulnerability and a sense that this kind of disaster could happen anywhere, to anyone, including children," says Russ Newman, PhD, JD, APA's executive director for professional practice.

Hotline callers had a range of concerns. "Some of the children simply asked, 'Why did this happen?' Some kids expressed fears that this could happen in their community," says Barbara A. Yutrzenka, PhD, who coordinated the debriefing of the hotline staff. "To me, they were all extremely relevant phone calls."

The bombing's impact on children may have been expanded by the compelling and pervasive images from Oklahoma. "Sometimes adults aren't aware what effect that has on kids who are watching TV with them," Yutrzenka says. "Some teachers thought this was not something they had to address because it wasn't in their community. We found out differently: It's obvious that kids think about and process these things."

Phone calls came from all over the country and from all age ranges, including adults who had concerns of their own.

The hotline was staffed by psychologists and other licensed mental health professionals mobilized by APA's Disaster Response Network. "The hotline gave children and parents the opportunity to discuss their reactions to the explosion in a confidential, anonymous, non-threatening atmosphere," says Jerry Jacobs, PhD, who directs the Disaster Mental Health Institute. "One of our goals was to help restore a sense of security."

In cases requiring more in-depth counseling, callers were referred to local resources. Additional information was sent to some callers' homes.

The five-day hotline project was preceded by two 30-minute television programs aired by local PBS stations in South Dakota. Schools with satellite capabilities were able to downlink the programs directly into classrooms. The audience asked Jacobs and other panelists about their reactions to the bombing.

APA conducted a similar hotline in 1991 during Operation Desert Storm and received 16,000 calls from across the country. The association launched the Disaster Response Network in 1992. Licensed psychologists, working through the Red Cross, have provided pro bono on-site disaster mental health services to victims and relief workers of disasters including the Midwest floods, Hurricanes Andrew and Iniki, the California floods and earthquake, the World Trade Center bombing, recent airline crashes and the Oklahoma City bombing.

For more information on the Disaster Mental Health Institute, write to the University of South Dakota's Department of Psychology, 414 E. Clark St., Vermillion, SD 57069.

Clinicians help heal post-trauma stress

Mental health experts acknowledge that post-traumatic stress disorder manifests itself in the weeks and months following a catastrophic event.

Mental health professionals dealing with children in Oklahoma City have observed an increased fear of loud noises and anxiety over absent students and teachers in the wake of the bombing of the federal building.

The state's mental health department, in conjunction with Oklahoma University's psychiatry department, assessed more than 15,000 students in grades six through 12. About 270 young people in the Oklahoma City public school district alone have experienced the loss of a significant family member. Students in 17 other school districts that surround Oklahoma City will also be screened.

The mental health department used funds from the Federal Emergency Management Agency (FEMA) to finance a facility and program specifically designed for disaster relief services. Named "Project Heartland," the program opened May 8 and is available to anyone who has been affected by the bombing, says Ann Lowrance, MS, the department's deputy commissioner for victim services.

Program staff handle crisis walk-ins and lead support groups. They visit families and survivors in their homes and make referrals to other agencies when necessary.

"What we're seeing now is that people are not numb anymore, and they're beginning to feel the pain and the anger," says Lowrance, adding that Project Heartland will operate for as long as its services are needed. "From what we are seeing now, that is going to be a long time."

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Coping with disasters

from page 1

onto the trauma of Oklahoma City. Children involved in the death or dying of people, pets or relationships in their "real" lives are more likely to take on the threat of the bombing. This directs our attention to already vulnerable children who have been exposed to the images and narrative of the attack on the federal building.

Third, we know that children exposed to vivid visual images of the traumatic violence of Oklahoma City are more at risk. In her book *Unchained Memories: True Stories of Traumatic Memories Lost and Found* (Basic Books, 1994), Lenore Terr, MD, offers the hypothesis that children who only receive a verbal narrative account of horrible events may develop a memory of these events, but that this memory will not be associated with traumatic symptoms (such as the re-enactment, emotional numbing and exaggerated startle response characteristic of true post-traumatic stress disorder). I believe Terr's analysis is valid, and it directs our attention to the flooding of many children with horrific images of damage and suffering that characterized the early days after the bombing as a potential source of threat.

Fourth, we know that the most important threat posed by widespread "exposure" to the bombing among children is the challenge of meaningfulness that trauma poses. Massachusetts clinician Bessel van der Kolk reports that 70 percent of his patients who experienced significant trauma before age 4 say they have given up all hope of finding meaning in their lives. Among those who were 25 or older when they experienced trauma, the figure is about 10 percent. This suggests to me that young children who do not meet the challenge of meaningfulness posed by trauma run a serious risk of ending up in deep psychological trouble, whereas those who do meet the challenge are better prepared to cope with their symptoms.

Fifth, we know that, given time, children will process and reconstruct the terrible events. Adults can play a positive role by providing a reality check of the emergent narrative memories of children as they remember and remember the events in the weeks, months and years that follow the actual events. Adults can facilitate this dynamic relationship as they treat the events as history.

When I put these issues together, I am left with a series of recommendations for parents and professionals who wish to contribute to the process of coping among children:

1. **Don't make assumptions one way or the other about how children feel.**

It's not always obvious what connections children see between themselves and others. The most likely danger is for adults to miss connections that children see. For example, during the Gulf War, I interviewed children who said they "knew" someone fighting in the Gulf because their music teacher's son (whom they had never met) was serving there.

By the same token, most children leave the news behind pretty quickly if it does not play an ongoing role in their lives. Children who lost parents may never truly leave the bombing site; most children will hardly remember it in a year.

2. **Look out for children who can't seem to let the bombing go.**

These children, who may incorporate the disaster into their play, stories or art work as a continuing theme, need the guidance of an adult to find a resolution. Children's TV host Fred Rogers suggests focusing on the people who came to help as one way to provide this guidance. This offers children a resolution that is positive in its implications for the future.

3. **Try to shield children from powerful visual images of the bombing and its aftermath.**

Where this is not feasible, focusing on reconstruction and "good news" follow-ups is important to address the issue of meaningfulness. One thing we might learn for responding to the next disaster is that raw images of suffering and harm should be off-limits for children. Telling them the story of the sad events is one thing; live television coverage of the dead and dying is another. Just as pornography is not the sex education strategy of choice, videotaped atrocities are not the way to teach young children about the meaning of human life.

4. **Focus on constructive activities that assert positive values for children.**

This means more programs that introduce children to the many trustworthy people in their social environments. It means reading stories about helpers and builders. It means age-appropriate social studies lessons on democratic values and culture. It means an emphasis on spiritual development.

When all is said and done, a horror like the bombing in Oklahoma City will have little impact on most children, some impact on some children, and devastating consequences for a few. However, the accumulation of such events can exert a negative influence of children and the childhood if adults mistakenly respond with paranoia, incapacitating anxiety or psychological inavailability because of preoccupation with trauma and its aftermath. These events are challenges and we should respond in a positive way with the expectation that we can help best by serving as role models: sympathetic but calm, concerned but helpful.

James Garbarino is director of the Family Life Development Center and professor of human development and family studies at Cornell University. He is the author of the forthcoming book *Raising Children in a Socially Toxic Environment* (Jossey-Bass, September 1995). He also developed an activity workbook for children called *Let's Talk about Living in a World with Violence* (Erikson Institute, 1993, $10). To order the workbook, contact Kathleen Kostelny at the Erikson Institute, 420 N. Wabash Ave., Suite 600, Chicago, IL 60611; (312) 755-2250, ext. 2244.

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WHAT'S NEW IN RESEARCH

Suicidal behavior is risk for teenagers with cancer

Clinicians should be alert for signs of suicidal behavior in young people with chronic illnesses. Of 35 adolescent cancer patients referred for psychiatric consultation, 15 showed evidence of suicidal behavior. The patients, 22 boys and 13 girls with an average age of 14.9, were rated on the Spectrum of Suicidal Behavior Scale. Ten patients expressed suicidal ideation; two had made suicidal threats; and three had made attempts on their lives. The precipitants of the behavior were relapse or progressive disease, initial diagnosis, depression and hopelessness, uncontrolled pain, arguments with parents and delirium.

"Suicidal behaviors in adolescents with cancer," E. Heiligenstein. Poster session presented at the American Academy of Child and Adolescent Psychiatry annual meeting, 1994. For reprints, contact E. Heiligenstein, MD, University of Wisconsin Health Services, 1552 University, Madison, WI 53705.

Unsafe school atmosphere may prompt dropping out

Students who feel unsafe at school are at risk of dropping out by 10th grade, according to a longitudinal study of 13,217 public school students. By 10th grade, 8 percent, or 200,000 adolescents, had dropped out of school. About a third of these dropouts experienced an unsafe school environment in eighth or 10th grades, or both. By comparison, 18 percent of those who stayed in school felt unsafe in eighth and/or 10th grade. The data were drawn from the National Education Longitudinal Study of 1988. Students and dropouts were surveyed at three time points: eighth, 10th and 12th grades. They rated the safety of their schools or the last school attended by responding to the statement "I don't feel safe at this school." In eighth grade, about 13 percent of the adolescents did not feel safe; two years later, about 9 percent did not feel safe. The validity of student reports was checked with several other indicators of school environment, such as theft, drugs, threatened harm and fights. Interestingly, students who feel safe in eighth grade, but unsafe two years later, may be most at risk. The odds of dropping out were almost three times greater for adolescents who reported feeling safe in eighth grade but unsafe two years later as compared to students who felt safe at both times. The findings support previous research on institutional violence. Viewed in light of this research, leaving school as a means of coping with chronic threats to personal safety becomes an adaptive, rather than maladaptive, strategy.

"Unsafe public schools and the risk of dropping out: a longitudinal study of adolescents," Tanja Bekhuis. Presented at the annual meeting of the Eastern Psychological Association, April 1995. For reprints, contact Tanja Bekhuis, PhD, TCB Research, 107 Willowbrook Drive, Boalsburg, PA 16827.

Speakers of 'black English' use complex syntax forms

Poor, urban black preschoolers who speak a lot of "black English" use more advanced syntax than their African-American peers who speak mainly standard English. That stereotype-shattering finding emerged from a pilot study of Detroit-area children conducted by University of Michigan researchers. The study of 45 African-American children between the ages of 4 and 5 1/2 analyzed a total of 4,000 utterances collected during adult-child conversations. Twelve of the children used African-American forms frequently, in about 30 percent of their speech. Another 19 children used black dialect 17 percent of the time, while the remaining 14 children spoke it only about 8 percent of the time. The more often children used African-American English, the more likely they were to also use complex syntax, such as gerunds and participles or two linked clauses. High users of African-American English used complex syntax about 12 percent of the time, while moderate and low black dialect users employed complex syntax only about 8 and 6 percent of the time, respectively. One goal of the project, according to the researchers, is to establish clear boundaries between black dialect and a host of language and speech disorders, estimated to affect up to one out of every 10 members of racial or ethnic minority groups. They are working with public schools in Oak Park, MI, where teachers and administrators are concerned that black children have been inappropriately placed in special education because of their speech patterns.

"The complex syntax skills of poor, urban, African-American preschoolers at school entry," Holly K. Craig and Julie A. Washington, *Language, Speech, and Hearing Services in Schools*, 25:181-190, 1994. For reprints, contact Holly K. Craig, PhD, Communicative Disorders Clinic, University of Michigan, 1111 E. Catherine St., Ann Arbor, MI 48109-2054.

Prozac may relieve OCD in children and adolescents

The antidepressant fluoxetine (Prozac), which has been shown to be effective in the treatment of obsessive-compulsive disorder (OCD) in adults, may help children and adolescents with OCD as well, according to a retrospective study. Almost three-quarters of the 38 pediatric patients in the study showed moderate to marked improvement of their OCD symptoms, according to their scores on the Clinical Global Impression Scale. They were taking doses that averaged 50 mg a day over an average follow-up period of 19 months, indicating that the benefits are lasting. Children and adolescents had similar outcomes.

"Fluoxetine in pre- and postpubertal obsessive-compulsive disorder," D.A. Geller, et al., presented at the American Academy of Child and Adolescent Psychiatry annual meeting. For reprints, contact D.A. Geller, MBBS, FRACP, at McLean Hospital, 115 Mill St., Belmont, MA 02178.

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Keep Your Eye On

... segregated schools.

Nearly half a century after the Supreme Court ordered public schools to be desegregated "with all deliberate speed," many of the nation's schools are more segregated than ever, according to a University of Michigan researcher. Illinois schools are the most segregated in the nation, and Michigan schools are next in line, according to John Rogers, an assistant professor of education. In Michigan in 1991-'92, 58.5 percent of all black children attended schools in which minorities made up at least 90 percent of the student body, compared to an average of 34 percent of black children nationally. The comparable figure for Illinois is 59.6 percent. Rogers participated in a conference earlier this month to commemorate the 40th anniversary of the Supreme Court ruling.

... Ritalin abuse.

Some teenagers are getting a cheap high off methylphenidate (Ritalin), a drug widely used to treat hyperactivity in children. In Muskegon, MI, where a student was recently arrested on charges of selling the medication to students who didn't need it, youngsters are buying or stealing Ritalin from classmates who are prescribed the drug. Kids crush the tablets and snort the powder like cocaine, or they cook the stimulant and inject it like heroin. Ritalin is a stimulant that calms children who have attention-deficit disorder (ADD) and helps them concentrate in class. But it has the opposite effect on children who don't have the disorder. (*The American School Board Journal*, May 1995)

... iron supplements.

A clinical trial by investigators at the Johns Hopkins Children's Center found that when teenage girls with iron deficiency, who did not have anemia, took iron supplements (260 mg elemental iron per day for eight weeks), they performed significantly better on verbal learning tests than girls who took a placebo. This finding could help the estimated 25 percent of adolescent girls in the United States who are iron deficient. Ann Bruner, MD, principal author of the study, says teenage girls should be regularly tested for iron deficiency because rapid growth and the onset of menstruation increase the body's need for iron. Bruner's study suggests that even in the absence of anemia, iron deficiency may impair learning in adolescent girls. Animal research has shown that decreased body iron negatively affects brain function by decreasing certain neurotransmitter levels.

... legal lessons.

Students at the Lynnbrook School for young offenders in Bethesda, MD, learn about the legal system as well as the regular high school subjects. School coordinator Susan Trus invited attorneys from the Public Defenders' Office and the States' Attorney's Office to develop a course on the U.S. legal system. "The goal of the program is to teach kids how to advocate for themselves," Trus says. She says that the visiting attorneys are also good role models for the students and that some of them have formed bonds with the youngsters. (*School Board News*, Jan. 31, 1995)

... new Head Start sites.

United Charities dedicated its first Head Start facility, located on the southwest side of Chicago, this year. The half-day preschool program has a total enrollment of 102 low-income children between the ages of 3 and 5. Parents are encouraged to get involved by joining the policy committee or volunteering in the program. (*UC Update*, spring 1995)

News Update

- The American Academy of Pediatrics (AAP) is recommending the newly licensed varicella (chicken pox) vaccine for universal use in early childhood, and for immunization in susceptible older children and adolescents. The AAP recommends that a single dose be given between 12 and 18 months of age. (*Pediatrics*, May 1995)
- **Societal and mental health problems** interact and exacerbate each other, according to a study that drew on the work of experts from more than 30 low-income countries. Communities with politically inspired violence, for example, often have high rates of alcohol abuse and domestic violence, which hurt children's development. (Associated Press)
- The **structure of family life** is changing around the world. Unwed motherhood, rising divorce rates, smaller households and the feminization of poverty are worldwide trends, according to a report called "Families in Focus," issued by the Population Council in New York. (*The New York Times*, May 30, 1995)
- A year after President Clinton signed the Brady Handgun Violence Prevention Law, at least 41,000 criminals have been prevented from buying **handguns** from licensed dealers, according to several surveys. Two to 3.5 percent of all applicants for handguns have been refused since the Brady Law took effect on Feb. 28, 1994, the surveys indicate. (*NCJA Justice Bulletin*, March 1995)
- Although they consider themselves ethical, only one in 20 college business students say they have never cheated in high school or college, according to a study by the University of Dayton and Wright State University. (*The Executive Educator*, June 1995)

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Speaking of Books

Disasters: Mental Health Interventions
John D. Weaver
Sarasota, FL: Professional Resource Press, 1995
220 pages (paper), $22.95
To order, call 1-800-443-3364

In the wake of disasters — both natural and human-made — lies a wide path of physical and psychological destruction. Long after the physical wounds have healed, the psychological devastation often remains. Disaster mental health is a growing field of practice designed to help the victims, and the helpers who rush to their aid, learn to cope effectively with the extreme stresses they will face in the aftermath of a disaster. This book, serendipitously published less than two months after the Oklahoma City bombing, provides an excellent combination of disaster crisis intervention information and application for all those who wish to be involved in this field.

The author, who has been an active volunteer with the American Red Cross throughout his career, has assisted at numerous local and national disasters, including the Mississippi River floods of 1993 and the 1994 crash of USAir Flight 427. Besides describing the psychological aftermath for survivors, Weaver explains how disaster strategies are planned, what motivates mental health workers in the field and how to avoid burnout. A portion of the proceeds from the sale of his book will be donated to the Red Cross.

Jeopardy in the Courtroom: A Scientific Analysis of Children's Testimony
Stephen J. Ceci and Maggie Bruck
Washington, DC: APA Press, 1995
312 pages (hard), $29.95
To order, call 1-800-374-2721

More than 200,000 children may be involved in the legal system in any given year. Upwards of 13,000 of them — disproportionately of preschool age — may be testifying in sexual abuse trials. According to the authors of this timely book, however, while even preschoolers are quite capable of providing accurate testimony, they are also more vulnerable through having their testimony and their memories distorted to the point that, in some cases, the truth may never be known.

The authors base their conclusions on a thorough review of the entire body of scientific literature on children's suggestibility and memory, and they illustrate many of their points with excerpts from records of actual cases, from the Salem witch trials to the Little Rascals Day Care case in Edenton, NC. A chapter on ethical and professional issues discusses the roles of mental health professionals as therapists, forensic interviewers and expert witnesses in cases involving children's testimony. They recommend that each of those roles be occupied by different people in a given case as each has a distinctly different job.

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Resources

STD questions answered

A brochure answers teenagers' questions about sexually transmitted diseases (STDs). "For Teens" tells readers how to avoid infection and what to do if they are diagnosed with an STD. It includes a special section on AIDS. **Cost:** Free. **Contact:** American Social Health Association, PO Box 13827, Research Triangle Park, NC 27709; 1-800-972-8500 before June 30.

Funding guide available

The all-new third edition of the *National Guide to Funding for Children, Youth and Families* features 3,400 grant sources for a range of programs, including abuse prevention, education, family planning, homelessness and youth development. The 1,028-page guide also includes grant-maker profiles, sample grants and cross-referenced indexes. **Cost:** $145. **Contact:** Foundation Center, 79 Fifth Ave., New York, NY 10003-3076; 1-800-424-9836.

Juggling helps readers

A new video advocates the benefits of learning to juggle for poor readers. Dr. Ingolf Mork, an 84-year-old juggling enthusiast who hosts the video, says that juggling, in certain specified patterns helps children establish a dominant hand and overcome learning disabilities he had noticed in ambidextrous individuals. **Cost:** $23.90. **Contact:** Mork Concepts Inc., PO Box 734, Winfield, KS 67156; 1-800-809-5156.

Tourette's on TV

Twitch and Shout, an intimate and humorous look at life with Tourette's Disorder, will be broadcast on P.O.V. Tuesday, July 11, on PBS nationwide. Check local listings. Filmmaker Laurel Chiten, who was diagnosed with Tourette's at the age of 28, shows the human face of the disorder.

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COMMENTARY

Disaster hits home

We have all seen the picture: A firefighter cradling the limp body of a baby, one impossibly small leg dangling over his arm like a strand of singed string. We learn her name later — almost-1-year-old Baylee Almon. We learn that she didn't survive.

If Vietnam was the first time that large-scale violence was brought into our living rooms, the Oklahoma City bombing was the first time it made its way to the nursery. Modern media provided a simultaneous sense of both the enormity and the personal impact of the destruction. We saw the nine-story Murrah building, blown open like a doll house. And we saw the private moments of personal grief — a motherless teenager bursting into tears, parents holding pictures of lost children. The coverage was immediate and pervasive. And kids were watching. How could they not, in a country where children watch 24 hours of television every week? These weren't just Midwestern kids. These were kids from all over. Children hundreds and thousands of miles from Oklahoma called a hotline last month (see story, page 3) to ask why. Why did it happen? Could it happen here? Could it happen to me?

This seems to be a quantitatively and qualitatively different response than usual. Does it make a difference that this is the real thing, that it's not Wile E. Coyote dynamiting himself off a cartoon rock ledge for the thousandth time? Barbara Yutrzenka, PhD, thinks so. She was one of the supervisors of the post-bombing hotline, co-sponsored by the University of South Dakota's Disaster Mental Health Institute. "Kids see these images on a daily basis, and they were clearly of real children and real characters and real grief," she says. "Kids can tell the difference between that and what's more sensationalized violence on TV."

We know they know; we know it bothers them. But this is also the country where half of 6- to 17-year-olds have their own TV sets. Someone has to talk to these young people — parents, teachers, counselors, whoever — and "help restore a sense of security," as the hotline director put it.

If any of these kids expected victims of the bombing to arise from the rubble and walk away accordion-style, a la Warner Brothers, they learned a harsh lesson. They have made the cruel discovery that there are, in fact, some things from which adults cannot protect them.

Melissa M. DeMeo, Associate Editor

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PS 025074

Indiana professor says toddlers can settle their own conflicts

By Melissa DeMeo
Associate Editor

Research

It will probably come as no surprise to people who work with young children, but disputes among toddlers break out every few minutes, according to a day care study. But teachers who are quick to intervene are missing a rich opportunity to advance children's social and cognitive development, says Cherie Bayer, PhD, who conducted the study for her dissertation at Ohio State University.

"Conflict is one of the major times two kids interact, and important things are learned through interaction," says Bayer, who is now an assistant professor of speech communication at Indiana University in Bloomington. "Teachers have to come to the idea that conflicts are very rich learning experiences. Then they have to know when to intervene and what to say."

Toddlers are more competent than the literature acknowledges in solving their own dilemmas. "The presumption is that toddlers can't do anything with their peers because they're too egocentric and don't have enough language and coordination skills," Bayer says. "We have

(turn to 2)

Joining forces with pediatricians

Clinical Issues

Funny how kids seem to get stomachaches right before they're supposed to catch the bus for school.

While the complicated relationships between physical conditions, such as gastrointestinal problems, and psychological factors have been documented in adults, they are just now garnering recognition in children and adolescents.

This emerging trend is making pediatricians see the wisdom of bringing psychologists and other mental health professionals on board to provide patients and their families with comprehensive and individually tailored care.

"Although the etiology of GI problems is not necessarily psychological, our experience has been that treatment that includes psychological intervention appears to be more successful than medical intervention alone for certain problems," says Carin Cunningham, PhD, a psychologist who works in a pediatric gastroenterology practice at Mount Sinai Medical Center in Cleveland, OH.

Controlled studies of collaborative treatment are few and far between, but descriptive studies appear to confirm Cunningham's statement.

Pediatric psychologists work with diverse populations, including young patients with GI disorders, cancer, and HIV and AIDS. "Overall, I think there has been a trend toward creative collaboration and training of psychologists in collabo-

(turn to 4)

This month's client handout: The lasting lessons of children's friendships

Toddlers

from page 1

data that say that's not the case at all. In this rich (day care) environment, these skills develop earlier than what Piaget or some other folks would have seen while looking at solitary children."

Children in day care enter a world of peers sometimes from the minute they sit up. Bayer conducted her research in the infant/toddler classroom at Ohio State's laboratory school. Over a nine-week period, she videotaped conflicts among 14 children, ranging in age from 3 to 34 months. She also observed how the five professional staff, six undergraduate student-teachers and two substitute teachers handled disputes.

Bayer found that small disputes erupted about every 2.6 minutes on an average day. The kids commonly argued about invasions of personal space, play procedures or who was entitled to a toy.

Teachers intervened in about half of the non-aggressive oppositional episodes. But when combined with the incidence rate, it turned out to be slightly more than 11 times every hour. "Teachers will respond to one (oppositional) move," Bayer says. "That's the key point of the study. It's not so much that kids oppose each other — because we all oppose each other off and on during a day. It's that the teachers actually make it into something that they respond to, and, by responding, construct a situation called a peer conflict."

Teachers often separated the youngsters without asking what the problem was or otherwise starting a negotiation process. At other times, teachers would assume they knew what the conflict was about and resolve it accordingly.

Bayer, who defines a dispute as the expression of opposition between two children, says that how children negotiate their disputes depends on their developmental stage. The lesson for teachers is to keep children's developmental capabilities in mind when deciding whether and how to intervene in a dispute.

"It's a continual process of knowing where the kids are developmentally," Bayer says. "It's only going to come from teachers who really know the children well."

Sometimes toddlers will work out their disagreements on their own; at other times, they may need help in reaching a happy compromise. For younger children, simply providing the words children need to negotiate for themselves is enough.

"If they don't know to assert themselves by saying, 'No, that's mine,' then what you first have to do is to give them the words," Bayer says. "They don't have it wired in their heads."

When children seem to reach an impasse, teachers can offer what Bayer calls "strategic assistance" by listening to each child's explanation of the conflict and then transmitting his or her concern to the other. Teachers may then offer solutions and demonstrate principles of negotiation.

In one of Bayer's videotapes, two children are disagreeing over who will push a toy shopping cart. After talking to each child and suggesting they do it together, the teacher offers the pair a choice. "You know what, guys? You both seem upset," the teacher says. "It seems like this is very hard. This is your choice: You can both do it together, or you guys can choose a different job to do."

"The two kids could not talk to each other because they were too caught up in the emotional part of the conflict," Bayer comments. "What the teacher does is carry the voice of one child to the other and vice versa."

Toddlers are also remarkably capable of tutoring their own peers. Kimberlee Whaley, PhD, an assistant professor of family relations and human development at Ohio State who supervised Bayer's research, tells the story of a little girl who carefully explained to a young classmate that he had upset a 9-month-old in their class. The young tutor had been a student of the day care since she was six weeks old. "If we do this with them from the time they're babies, this process can work," says Whaley, who is also coordinator of the infant-toddler program at Ohio State's A. Sophie Rogers Infant-Toddler Lab School.

Toddlers can get it, and what better way for them to learn *how* to do this than in the process of learning their language.

— Cherie Bayer, PhD

For the little boy, the lesson was clear. "He got the message, and he got the message, not from the teacher, but from one of his peers," Bayer says. "This shows that toddlers can get it, and what better way for them to learn *how* to do this than in the process of learning their language?"

The more ways they know how to communicate with others, the more adaptable kids will be. "Communication research with college-age students suggests that the larger your repertoire of skills, the more competent you will be in terms of being able to get what you want and in the appropriate fashion." ■

You can write to Cherie Bayer at the Department of Speech Communication, Indiana University, 809 E. Seventh St., Bloomington, IN 47405-3999; e-mail: cbayer@indiana.edu.

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ON CAPITOL HILL

Kids' programs face the ax

The mood in Washington toward children has turned unfriendly in recent months, according to many concerned with children's mental health issues, and to some advocates, recent developments on Capitol Hill have been downright malicious.

"We've got a war going on in Washington," says Al Guida, vice president for government affairs at the National Mental Health Association (NMHA). "What we have in Washington is specific targeting ... against children with specific mental disorders."

"The safety net is being torn apart by the new Congress," adds Michael M. Faenza, MSW, president and chief executive officer of the NMHA.

In particular, recent debate over Supplemental Security Income (SSI), which provides maintenance income to the blind, aging and disabled, turned to children with mental disorders as a source for entitlement cuts. About $4.5 billion in the SSI program goes to 250,000 children with mental health disorders. Proposals from the House of Representatives to eliminate the Individual Functional Assessment, the tool that determines SSI eligibility for children with mental disorders, would cut about 225,000 of those children from SSI rolls, Guida says.

The rhetoric on Capitol Hill is that "these children need services, not cash," Guida says. But as with any disability, dealing with a child with serious emotional problems drains a family's resources, he says, creating additional expenses while cutting into a family's earning potential, just as it does in cases of children with physical disorders such as spina bifida and cerebral palsy.

Guida has been appalled by "the incredible ignorance of members of Congress to mental disorders in children." Evidence of societal stigma was in abundance recently as the House debated the merits of diagnoses such as attention-deficit hyperactivity disorder, appearing not to understand that "not taking out the trash, or failure to make the bed, is not analogous to burning down the garage," Guida says.

Harmful to Congress's perceptions of children's mental health was a recent television newsmagazine report documenting SSI abuses by parents claiming that their children suffered from a mental disorder. (See "Keep Your Eye On," page 6)

Responding to these reports, the House has voted to cut off aid to 225,000 children, all on the basis of perhaps a dozen documented cases of abuse, Guida says. The cut is included in a welfare reform package that the Senate is now considering.

An unpleasant surprise for mental health advocates came from the ranks of the American Academy of Pediatrics (AAP) when that group's lobbyist proposed to a House subcommittee actions that would take away SSI benefits for children with serious emotional disturbances and behavioral disorders. "If even the AAP misunderstands the needs of kids with emotional disturbances, no wonder policymakers are confused and wrongheaded," Faenza says.

But all may not be lost in Washington, as children's advocates turn hopefully to the Senate. The stakes in this debate are high. "If we can't save kids in SSI, we can't save anything," says Chris Koyanagi, co-director of government affairs at the Judge David L. Bazelon Center for Mental Health Law. "If we can't help those kids, who are we going to help?"

Reprinted from the May 1 issue of *Mental Health Weekly*, sister publication of *The Brown University Child and Adolescent Behavior Letter*.

NEWS UPDATE

- Teenagers may avoid going to the doctor because they are afraid of getting AIDS, according to a survey of more than 6,800 ninth-graders in Philadelphia. During discussion groups, most teenagers guessed that 100,000 to 250,000 Americans with the HIV virus were infected by health professionals. The actual number is 6. (*Journal of the American Medical Association*, June 28, 1995)
- The all-black North Vista Elementary School in Florence, NC, might become the site of a five-year experimental school with an accelerated curriculum and a school day of 10 to 12 hours. According to a proposal to the school board, students — from 2-year-olds to sixth-graders — would wear uniforms, receive three meals a day and do their homework at school. (*School Board News*, June 27, 1995)
- A preliminary study suggests that a new genetically engineered influenza vaccine can protect people from the flu, with fewer of the minor side effects associated with the currently licensed flu vaccines. The new vaccine contains a purified, recombinant version of a protein called hemagglutinin, normally found on the surface of influenza A virus. (*Journal of Infectious Diseases*, June 1995)
- The clash between health care providers and managed care companies may produce a health care system that is at once more personal than today's cold business-like atmosphere, and more efficient than yesterday's cost-blind private practice, according to experts at a debate held by the Institute of Medicine of Chicago. "Managed care is not a destination, but a journey," said James Todd, MD, executive vice president of the American Medical Association. (Reuters)

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Joining forces

from page 1

ration," says Dennis Drotar, PhD, who trains students in a pediatric psychology program at MetroHealth Medical Center in Cleveland.

One of the most important ways to build a collaborative practice is to "establish an effective working relationship that's going to last over time," says Drotar, editor of *Collaborating with Pediatricians* (Plenum, 1995).

Cunningham advises psychologists to learn about the symptoms, treatment and natural course of the disorders commonly presented by patients in the practice. In her work with the gastroenterologists, she studied the impact of GI problems on children and families, as well as the interplay between physical problems and children's psychological functioning over time.

"With experience, I developed psychological services to fit the needs of this population," says Cunningham, who wrote a chapter based on her experiences for Drotar's book.

She employs behavior modification, relaxation training and individual psychotherapy for patients in the practice, as well as counseling for parents. Patients get referred to Cunningham's office for a number of reasons: They won't comply with their medical treatment plans; they refuse to go to school; they're having trouble eating or going to the bathroom; or they seem to be depressed.

She says this collaborative approach has been well received by both patients and parents — because it works. It's also easier on families. "The consumer-friendly features of this service include easy access to mental health care; integration of pediatric health and mental health care; and acceptance by parents of services, making it easier for the child," she says. ■

Tips for helping GI patients

Editor's note: Psychologist Carin Cunningham, PhD, offers this sampler from her work in a pediatric gastroenterology practice at Mount Sinai Medical Center.

Inflammatory Bowel Disease (IBD)

Psychological intervention with newly diagnosed patients helps the child and family accept and manage symptoms, such as diarrhea, fatigue, weight loss and pain. Support is also needed to meet the extraordinary demands of immediate care, such as nasogastric tubes, dietary restrictions and diagnostic procedures. Patients experiencing a recurrence of their symptoms are usually depressed, frustrated and fearful, with the growing awareness that they have a chronic illness whose course is unpredictable. Most of them become less distressed following collaborative intervention, including time-limited supportive psychotherapy during hospitalization and outpatient follow-up. Psychologists can also help patients comply with their medical treatment regimens.

Encopresis

Typically, children with encopresis feel ashamed, isolated and guilty. Their parents do, too. The psychologist's role in the collaborative treatment needs to be direct and matter-of-fact and to include an educational component. A behavior modification plan for the individual child and support for the parents works well in these cases.

Ulcer Disease

Pediatric ulcer disease patients are typically referred to determine if and what emotional stresses are affecting the course of the illness. Identifying the salient stressors in a child's life — family conflicts, learning problems and social isolation — is helpful in decreasing their impact. Other approaches include devising coping strategies by which children and families can better manage the disease, providing individual psychotherapy and teaching relaxation training to the child.

Recurrent Abdominal Pain (RAP)

Children who present with RAP are referred for psychological evaluation when the degree or type of their pain is not consistent with physical findings and/or when the child presents with associated problems, such as school avoidance or depressive symptoms. Intervention with RAP patients requires close communication with the gastroenterologist and includes: reduction of child's secondary symptoms; involvement of parents in psychological treatment; and individual psychotherapy and stress management, including relaxation techniques, for the child.

Feeding Problems

Pediatric feeding disorders can result from the sequelae of medical problems, and frequently involve a stressful parent-child relationship. Behavioral treatment of feeding problems has been most helpful. Close medical follow-up is critical to help parents maintain a demanding behavioral program and to address their fears about their children's physical health.

For more information, you can write to Carin Cunningham at Mount Sinai Medical Center, Department of Pediatrics, 1 Mount Sinai Drive, Cleveland, OH 44106-4198, or call her at (216) 421-4099.

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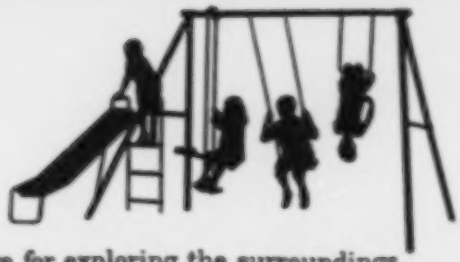
Your child's friendships provide important and lasting lessons



Contrary to popular belief, the best indicator of how well your child will adapt as an adult is not school grades, but peer friendships, according to Willard W. Hartup, Ph.D., a specialist in child development at the University of Minnesota. "Peer relations contribute substantially to both social and cognitive development and to the effectiveness with which we function as adults," he says.

Hartup says that friendships in this stage of development provide four basic functions that help children in their journey toward adolescence and adulthood. These functions are:

1) **Emotional resources** — for having fun, and for dealing with stressful situations or events;

2) **Cognitive resources** — for problem solving, and for acquiring knowledge;

3) **Social contexts** — for acquiring and enhancing basic social skills, such as communication, cooperation, and group entry; and

4) **Relationship models** — as a context in which to understand subsequent relationships.

Above all, says Hartup, friendships tend to be based on equality, in contrast to adult-child relationships. Friends are similar to each other, engaging each other mostly in play and socializing.

Emotional and cognitive resources

As emotional resources, friendships provide children with the security to meet new people, explore new things, and tackle new problems, says Hartup. Friends set the emotional stage for exploring the surroundings, and support the processes involved in just having fun.

In addition, several studies have indicated that friendships actually help to buffer children and adolescents from the adverse effects of negative or stressful events, such as family conflict, illness, or school problems. It is important to note, however, that gender is a significant factor in these situations.

Some research has suggested that during stressful times, school-aged boys tend to turn to their friends readily, in an attempt to distance themselves from the troubling event or environment. Girls, on the other hand, may tend to withdraw from friends, or enter into friendships more cautiously.

Children also provide cognitive resources for their friends. Friends teach one another in a variety of situations. Mimicking — in speech mannerisms, or in clothing choice, for example — is common among childhood friends. Studies of peer collaboration indicate that friends who collaborate to complete a task show greater mastery over that task than nonfriends who collaborate. Friends talk more, says Hartup, take more time to work out differences in their understanding of game rules, and compromise more readily than nonfriends do. These conditions make friendships a unique context for learning, he says.

A model for future relationships

Children's friendships can be considered as templates for subsequent relationships, says Hartup. While new relationships are never exact copies of old ones, the organization of behaviors and skills learned in relationships often transfer from old ones to new ones. For

Continued on next page . . .

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example, smoothly functioning friendships have been shown to rub off on relationships between preschool children and their younger siblings.

The hazards of poor social adjustment

Because children's social development begins in their early years, it is extremely important for you, as parents, to be aware of your children's social attributes, say Diane McClellan, Ph.D., and Lilian G. Katz, Ph.D., both specialists in child development. The risks for children who are unable to adapt to their peer culture are many, they say, including poor mental health, dropping out of school, low achievement, and other school difficulties.

McClellan and Katz have developed a social attributes checklist as a guideline for assessing your child's social development. It is important to remember, however, that this is only a guideline and not intended to dictate all the behaviors or characteristics your child must have. Each child is developmentally unique, and should be encouraged to develop at his or her own pace. This list of attributes should be considered in that context.

Parents can discuss this list as it relates to their children with teachers, school counselors, or other appropriate caregivers.

This checklist indicates adequate social growth if they usually characterize the child. Occasional fluctuations in mood do not necessarily suggest long-term difficulties. However, if your child seems to be doing poorly on many of the items on the list, you should consider speaking with a school counselor or your physician. There may be some underlying problems that need professional attention.

The Social Attributes Checklist

I. Individual Attributes

The child:

- ☐ is usually in a positive mood.
- ☐ is not excessively dependent on teachers or other adults.
- ☐ usually engages in activities willingly.
- ☐ usually copes with rebuffs adequately.
- ☐ demonstrates the capacity to empathize.
- ☐ has positive relationships with one or two peers — *i.e.*, indicates genuine care for them, misses them if they are absent from school, *etc.*
- ☐ displays capacity for humor.

II. Social Skills Attributes

The child usually:

- ☐ approaches others positively.
- ☐ expresses wishes and preferences clearly.
- ☐ is not easily intimidated by bullies.
- ☐ expresses frustration and anger appropriately, without harming others or property.
- ☐ takes turns fairly.
- ☐ negotiates and compromises with others.
- ☐ shows acceptance for peers of other ethnic groups.
- ☐ is accepted fairly easily into ongoing activities or groups.
- ☐ interacts nonverbally with other children with smiles, waves, nods, *etc.*

This chart has been adapted with permission, from "Assessing the social development of young children: A checklist of social attributes," *Dimensions of Early Childhood*, Fall, 1992, pp.9-10.

Source: Office of Educational Research and Improvement, U.S. Department of Education.

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Prepared by Mary-Kim Arnold, editorial assistant.

WHAT'S NEW IN RESEARCH

Dating violence common at Los Angeles schools

From pushing and shoving to kicking and hitting, violence pervades the dating relationships of Los Angeles high school students, a University of Southern California study shows. Nearly half the respondents (48 percent) to a survey of 938 urban Los Angeles County high school students said they had been victims of dating violence or had used violence against a date. Compare this to less than 20 percent in studies sampling high school students in suburban and rural areas. The types of physical aggression most frequently inflicted or experienced on dates by the LA sample were pushing, grabbing or shoving; throwing something; slapping; and kicking, biting or hitting with a fist. Violence that could cause more serious injury — such as beating up, threatening with or using a gun or knife — was rarely reported. The survey did not ask about sexual violence, such as rape.

Current research by Maura O'Keefe, PhD. For more information, contact her at the School of Social Work, University of Southern California, MRF #204, Los Angeles, CA 90089-0411.

Anorexia poses serious risk of mortality

The mortality rate for patients with anorexia nervosa is not only greater than that of the general population, but also of women in psychiatric hospitals, according to a meta-analytic study. The study combined the crude mortality proportions from 42 published studies of 3,006 individuals diagnosed with anorexia to estimate the mortality associated with the eating disorder over time. The crude rate of mortality — the proportion of subjects who were dead due to all causes at the time of follow-up — was 5.9 percent. When the length of follow-up and number of subjects were taken into account, the aggregate mortality rate was estimated to be 0.56 percent per year, or about 5.6 percent per decade. That's 12 times higher than the annual death rate due to all causes of death for young women ages 15 to 24 in the general population. It's also more than twice that of a national study group of female psychiatric inpatients 10 to 39 years old.

"Mortality in anorexia nervosa," Patrick F. Sullivan, *American Journal of Psychiatry*, 152(7):1073-1074, 1995. For reprints, write to Patrick F. Sullivan, MD, University Department of Psychological Medicine, Christchurch School of Medicine, PO Box 4345, Christchurch, New Zealand.

OCD, Tourette's may be part of same continuum

New research suggests that obsessive-compulsive disorder (OCD) and Tourette's syndrome may be on the same continuum. The study involved 20 adult outpatients with OCD without tics or Tourette's syndrome; 21 adult Tourette's patients without OCD; and 20 patients with both Tourette's and OCD. They were evaluated with the structured clinical interview for DSM-III-R (SCID) and a phenomenologic interview. Repetitive behaviors in patients with pure OCD were more frequently associated with cognitive and autonomic phenomena than in those with pure Tourette's. Sensory phenomena preceded repetitive behaviors in Tourette's without OCD more frequently than in OCD patients without tics or Tourette's. Patients with both disorders reported high severity and frequency of all three types of associated phenomena, indicating that the two disorders may be related. In another study of the same subjects, the researcher found that the adults with pure Tourette's and pure OCD had similar lifetime rates of major depression, panic disorder and agoraphobia without panic. However, the patients with both disorders appeared to be at significantly elevated lifetime risk of bipolar disorder and marijuana and cocaine abuse and nearly significantly elevated rates of alcohol dependence.

"Phenomenology of obsessive-compulsive disorder and Tourette's syndrome" and "Tourette's disorder and obsessive-compulsive disorder: comparison of comorbidity," B.J. Coffey, et al., presented in poster session at the annual meeting of the American Academy of Child and Adolescent Psychiatry, October 1994. For reprints, write to B.J. Coffey, MD, McLean Hospital, 115 Mill St., Belmont, MA 02178.

Opiate addicts' kids at risk for problems

Children of opiate addicts with comorbid psychiatric disorders may be at particularly high risk for psychiatric disorders and impaired functioning. In a recent study of 117 opiate-dependent parents and 155 of their children, aged 7 to 17, children were assessed by raters blind to the parents' diagnoses. The most frequent comorbid disorders in parents included major depression (47 percent), cocaine abuse/dependence (59 percent), posttraumatic stress disorder (11 percent), and antisocial personality disorder (9 percent). Preliminary analyses indicate that children of addicted parents with either antisocial personality disorder or cocaine abuse run a higher risk of conduct disorder and possibly attention-deficit hyperactivity disorder. Parental depression was associated with trends toward increased rates of children's depression, and parental depression and cocaine abuse were each associated with kids' lower scores on the Children's Global Assessment Scale. The findings suggest that these children should be targeted for prevention and early intervention strategies.

"Comorbidity in parents and disorders in children," Rise B. Goldstein, et al., presented in symposium at the American Psychiatric Association, May 1995. For reprints, write to Rise B. Goldstein, PhD, Psychiatry, Columbia University, 722 W. 168th St., Unit 14, New York, NY 10032.

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Keep Your Eye On

... shy kids.

Very shy and cautious 2-year-olds may have a higher risk of anxiety problems later on, says a study that examined such kids around age 13. Very inhibited toddlers were more likely than their very outgoing peers to be anxious around people when they reached 13, according to Harvard psychiatrist Carl Schwartz. The study also found that kids classified as very inhibited when they got older ended up with results on a psychological test similar to those found in adults with panic attacks, phobias, general anxiety or posttraumatic stress disorder. (Carl Schwartz, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115)

... fatherless families.

The percentage of American children in families without fathers has increased fourfold since 1950, a trend that continues unabated, a new study concluded. The sixth annual *Kids Count Data Book* reports that the percentage of American children living in mother-only families has increased from 6 percent in 1950 to 24 percent in 1994. This trend has been matched by an even more rapid rise in the percentage of young men with earnings below the poverty level for a family of four — no coincidence, according to the researchers. (Annie E. Casey Foundation, 701 St. Paul St., Baltimore, MD 21202, (410) 547-6600)

... disability payments.

A year-long study refutes some lawmakers' claims that parents coach their children to act crazy in school so they can collect money from the Supplemental Security Income (SSI) program. The study found instead that the program allows families to care for severely disabled children at home rather than institutionalize them. SSI costs far less than paying for foster care, group homes or institutions, the report said. Research cited in the report found the cost of out-of-home care for a disabled child ranges from about $24,000 a year for specialized foster care to $95,000 in a state institution. (National Academy of Social Insurance, 1776 Massachusetts Ave., NW, Suite 615, Washington, DC 20036, (202) 452-8097)

... juvenile justice.

Evidence from several studies indicates that early childhood education can reduce low-income children's prospects for later involvement with the criminal justice system. The High/Scope Perry Preschool Project study conducted when those who had participated in the preschool program reached age 19 and again when they were 27, showed lower delinquency and arrest rates for the preschool participants. By age 27, 58 percent of program participants had been arrested, compared with an arrest rate of 69 percent for the control group. ("The Implications of Early Childhood Services for Juvenile Justice," Chapter 4 of *Early Childhood Care and Education: An Investment That Works*, published by the National Conference of State Legislatures, Marketing Department, 1560 Broadway, Suite 700, Denver, CO 80202, (303) 830-2054)

... the Net.

They're better at it than we are, and students are using computer online services for everything from information retrieval to pen pal exchanges to scientific data bases. One seventh-grader from Washington, DC, says that her e-mail messages to friends in Australia, Slovenia and Argentina have helped her understand the basic similarities of people. (*The Internet Manual for School Users*, published by Educational Research Service, 2000 Clarendon Blvd., Arlington, VA 22201, (703) 243-2100)

Resources

Newsletter focuses on improving girls' lives

Editors of a new publication called *Growing Girls International* want to provide a forum for sharing information and experience among people who work to improve the lives of girls around the world. Each issue — available in on-line and print forms — focuses on a specific topic related to the growth and development of girls and young women from birth to age 19. The August issue will examine examples of efforts to build "girl-friendly" communities. **Cost:** Free. **Contact:** Dr. Margaret Sutton, Academy for Educational Development, 1875 Connecticut Ave., NW, Washington, DC 20009; e-mail: psutton@aed.org.

Violence experts talk about young children

Experts from the fields of child development, education, health and human services come together to offer ways to lessen the impact of violence on children under the age of 8. The 17-minute VHS video, *Violence and Young Children: Reducing the Risks*, was taped at a conference in Oakland, CA. **Cost:** $40 (purchase), $15 (rental). **Contact:** Violence and Young Children Video, Contra Costa County Prevention Program, 75 Santa Barbara Road, Pleasant Hill, CA 94523; (510) 646-6511; fax: (510) 646-6520.

How to help children cope after a disaster

A new brochure, "When Disaster Strikes: Helping Children Cope," explains the symptoms of stress in young children, what adults can do to help, and what teachers need to do to take care of themselves. **Cost:** 50 cents, $10 for 100. **Contact:** National Association for the Education of Young Children, 1509 16th St., NW, Washington, DC 20036; (800) 424-2460; fax: (202) 328-1846.

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At the Library

How do you deal with a bully? Avoidance? Standing up for yourself? Telling? There is no one answer to this old question, but the following books will show young children they are not the only ones to face this problem, as well as ways to deal with it. These books, which are suitable for 4- to 8-year-olds, are available at most public libraries.

The Berenstain Bears and the Bully by Stan and Jan Berenstain, Random, 1993. When Sister Bear comes home from school battered, dirty and bruised, her family learns she was beaten up for no reason by a rough new cub named Tuffy. Brother Bear wants to "clean Tuffy's clock" but finds out that Tuffy is a girl and backs down. Instead, he coaches his sister in self-defense and she has to use it when avoidance doesn't work. Sister Bear also learns that Tuffy gets hit at home.

The Rat and the Tiger by Keiko Karza, Putnam, 1993. Although Rat and Tiger are best friends, Tiger always takes advantage of Rat, who is smaller. Tiger always gets to be the good guy when the pair play games and always takes the bigger piece when they "share" something. One day, Tiger goes too far, and Rat, although scared, has to stand up for himself.

Tyrone the Horrible by Hans Wilhelm, Scholastic, 1988. The world's first big bully, Tyrone the Horrible is bigger and stronger than all the other dinosaur kids. He especially likes to tyrannize Little Boland dinosaur. Boland's well-meaning friends give him a variety of advice: Make friends with Tyrone; keep out of his way; give him a present; stand up to him; learn to live with him. Little Boland tries them all, but finally has to come up with his own solution.

The following two books are about bullies, but the hero in each is saved by the intervention of a relative.

Timothy and the Big Bully by Jeffrey Dinardo, Simon and Schuster, 1988. Class bully Big Eddie picks on Timothy by taking his lunch. The next day, Timothy tells Mama he's sick, but she says he looks fine to her, so he has to go to school. The day after that, he tells Mama school is closed, but Mama sends him anyway. Eddie finally stands up for himself, but the surprise entrance of his big brother on the scene really helps.

Monster Mama by Liz Rosenberg, Philomel Books, 1993. In this fanciful story, Patrick Edward's mom is really a monster, but she's also a fierce mother. She lives in a big cave at the back of the house and is really pretty weird, but Patrick Edward thinks she's the best Mama in the world. When Patrick Edward is sent to the store to get something lovely for dessert, three bullies pounce on him. Their mistake: It's Monster Mama to the rescue. She not only saves her son, but transforms the bullies into friends.

Barbara Goldberg, MLS, is a contributing editor to *All Kids Considered*, an independent parenting publication.

The Body Atlas, New Edition
Mark Crocker
NY: Oxford University Press
64 pages, $16.95 (hard), 1994
To order, call 1-800-451-7556

First published in 1991, this beautifully designed, excellently illustrated book explains the human body and its functions. It is perhaps the finest, most interesting anatomical reference for 7- to 12-year-olds that there is.

Speaking of Books

Child Abuse: A Multidisciplinary Survey
Byrgen Finkelman, Editor
Hamden, CT: Garland Publishing
10-volume set, $640, $55-$78 by volume (hard), 1995
To order, call 1-800-627-6273

A truly encyclopedic compilation of historic articles, this series of 10 volumes covers virtually the entire history of child abuse *study* (after all, child abuse itself is as old as human history). The story begins with three seminal articles, including one by Elizabeth Elmer, who noted in 1960 that little was yet known about child abuse or methods for dealing with it. C. Henry Kempe is author of two others, one on "parental criminal neglect" (1959) and one on "the battered-child syndrome" (1962).

This is a set essentially of reprinted articles, arranged chronologically — a setup that fills in a compelling timeline of research and early efforts toward prevention. Interestingly, the first volume, *Physical and Emotional Abuse and Neglect*, makes it clear that the first organized efforts to prevent child abuse were sponsored largely by physicians and lawyers.

The editor, a lawyer and writer who has worked with adult survivors of child abuse, emphasizes in her introduction to each volume the interdisciplinary origins of interest in the abused child phenomenon.

Most, if not all, of the prominent names in the field of child abuse are represented in these 10 volumes. The set, obviously in a price range principally for libraries, other institutions and perhaps group practices, is a worthwhile bibliographic organization of relevant literature to date. Exemplary volume titles are *Causes, Prevention and Remedies*; *Treatment of Child and Adult Survivors*; *Perpetrators, Victims and the Courts*; and *Child Abuse Legislation*.

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COMMENTARY

Advice on handling conflicting advice

Browsing in the magazine shops between airplanes can be a very edifying experience. What impresses me especially is that parents today know they are living in a volatile world and an era of fast cultural change. Judging from what I see in most magazines designed to help parents be parents, everyone is looking for *the* answer, a quick fix, a ready remedy, an all-purpose solution. Article after wonderful article tells you what to do, and gives you the advice in the form of "bullets," posing as great shots at child-rearing. The messages are often neither clear nor consistent.

- Punishment humiliates your child. *BUT*: Do let your child know you don't like what he did.
- Lay the rules down for your adolescent daughter. *BUT*: Be careful not to over-control your children.
- Tell your son his girlfriend can stay for the weekend. *BUT*: Don't let your son change your moral standards.

There is an assumption out there that parents don't know what to do any more, and must turn to authorities for guidance. They grew up in what they acknowledge to be "a different time," and they believe that their own value systems may be suspect. Lack of confidence in themselves causes them to look elsewhere for guidance, and they turn to the "authority" of the magazine and its editorial staff as the final arbiter of what is good and useful and safe in child-rearing.

But who decides on the editorial boards, and who are the writers? True, they are usually "authoritative" individuals, but they themselves are living in a social and professional context. Their advice is often time-bound and culture-driven. Here is a case in point: Some years ago, nationally prominent pediatricians and child psychologists advised the U.S. Maternal and Child Health Bureau, for their popular child-rearing pamphlet, that if a child is found masturbating, his (sic) hands and legs should be tied to the sides of the crib to prevent its recurrence. It is doubtful any "authority" would today advocate such a measure.

Authoritative advice to parents is affected both by the vagaries of social change as well as increasing knowledge. What is relevant in Uganda or Michigan may not be for Ohio or Hawaii. Individual differences in families and individuals abound. While there are some universally acceptable values to rear a child with — such as instilling a good self-concept and a feeling of responsibility, and laying the foundation for a caring attitude toward others and oneself — the style in which this is done successfully may vary appreciably from one family to another, one culture to another, and even from child to child in a family.

Every parent today has to be a fast read. For fast-reading parents and their counselors, and for teachers and others, I have a few "bullets" of my own:

- Don't believe all the bullets you read!
- Remember that *all* kids are different, even in the same family, and that is the wonder of childhood — and of humanity.
- Don't treat children as if they are best treated by word bullets.
- Try not to get jerked around by bullets.

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Vol. 11, No. 8 August 1995

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Some safe havens are orphanages

By Lewis P. Lipsitt, PhD
Editor

Analysis

Orphanages once were institutions for children without parents who could care for them. This could mean that both biological parents had died (very low incidence); that the parents absconded (rare); that the mother would be chastised by society if she kept the baby (not uncommon); or that there was no known father and the mother lacked the resources to take care of the child (very much more likely).

Earlier this year, House Speaker Newt Gingrich created a fury with his political reference to orphanages. Over the ensuing months, I've given thought to the often angry, sometimes incredulous, response his remarks generated. I think it is important that we know what we are talking about when we say *orphanage*.

An orphanage has always been meant to be a place of refuge, for parents or children, or both. Traditionally, orphanages attempted to provide a safe haven where children could be taken care of when a biological parent was not available for comfort and safety.

More recently, an orphanage is a place where a child, often with some disability and rejected by the parents, could be cared for.

Somehow the image of Boys Town became linked politically and sociologically to orphanages. The

(turn to 2)

Right conditions for learning rarely converge in classrooms

By Melissa DeMeo
Associate Editor

Education

Despite our self-image as a uniquely adaptable and intelligent species, learning is rare in most circumstances, according to a group of theorists. "This is a pretty outrageous assertion," admits David Perkins, PhD, co-director of Harvard University's Project Zero. "It's a scary notion, a notion that's hard to live with."

Scary as it may be, it's an idea that might prove helpful in the long run. "It sharpens the vision of what might have to be done to make learning more frequent," he says.

This has clear implications for the classroom, where students sit for 50-minute stretches and absorb far less than teachers and textbook authors think they do. "Learning tends to be much rarer than is possible for the human organism," says Perkins. "Students sitting through that same 50 minutes, configured somewhat differently, could be learning far more than they usually do."

But students' cognitive capacity is not entirely to blame, according to the rare events perspective on learning.

"Good learning conditions are often difficult to establish, and kids will plateau; they will go for a long

(turn to 3)

This month's client handout: Teach your child how, not what, to think

Orphanages

from page 1

Town was a safe haven — for children who had been difficult to rear, or who had gotten into trouble with the law or with their parents.

We came as a society to love or even revere Boys Town — with the help of a tear-jerker movie starring Bing Crosby and Barry Fitzgerald ("Oh, by gum and b'gorry," how can we forget?), because it was a place where a needy kid in trouble could go and find a friend or a dozen friends and perhaps grow up OK.

Boys Town reified the prospect of a child growing up in adverse circumstances and turning out to be a good citizen. The essence of a child in Boys Town was a kid headed for bad things, with no seeming attachment to anyone and little hope for the future, developing camaraderie — hanging on to others: "He ain't heavy, Father. He's my brother."

"Father" was, indeed, a *protective factor*, as developmental psychologists have come to know these *immunizers*, individuals in the lives of children at peril for terrible outcomes. These are folks who can take a risky child and turn him (her, too — but it *was* Boys Town).

Above all, "orphanages" were places where the adults could be trusted with children and adolescents. They did good, not harm. Or so they should have, and should do. These domiciles are home for kids who don't have a caring, comforting core family, and don't have a place called home.

It is hard for a person who grew up in a traditional home to understand what a roof over the head, a warm bed, the prospect of breakfast, and a close-by caring human can mean to a bereaved child abandoned and alone in the universe. Bing Crosby and Boys Town helped us grasp the empathy involved, the attachment that we know so well as fundamentally important, absolutely necessary for a kid to grow up well.

Today an institution for the care of a wayward child, or a child of wayward parents, can take many forms. These places don't have to be warehouses. Very frequently, a government-run institution *can be* more of a safe haven, with greater opportunity for better relationships with other persons than in a foster home where the child is often seen as a reject, a non-permanent guest in someone else's home.

Children who are not protected by a biological or adoptive family must have shelter and at least one person who has taken on this child as 'my love.'

As William Raspberry says, what every kid needs perhaps as much as food and a bed is someone whose hope rides on them. Children who are not protected by a biological or adoptive family must have shelter and at least one person who has taken on this child as "my love."

The safest way of assuring this is through institutional care delivered by individuals whose life mission is the nurturing of these children. That has been the magic of Boys Town: It's a place where (as Robert Frost said) when you go there they have to take you in and let you call it home.

Our government and numerous private agencies have long supported havens for the poor and down-trodden. Gingrich didn't invent these places. He may never have visited one or sat on the board of one. If he wants to help improve those that presently exist, and wishes to found more of them for *truly excellent* care of youngsters, a condition that is not only compassionate but is cost-effective, let us support this.

We surely need environments of quality for children of abject poverty and neglect whose parents cannot provide both food and nurturance. We have personal and social obligations to look after children who are physically and psychologically abused, or whose parents are so strung out on drugs that they hardly know they have a child, or that their own behavior produced the child, or that their behavior now has anything to do with the way the child will live, thrive if lucky, and die.

Orphanages — child-caring institutions — are not inherently bad for children. Lots of fine individuals have grown up with "families" that *really* have cared for them. ■

Announcements

- Zero to Three, National Center for Clinical Infant Programs, will convene its 10th National Training Institute in Atlanta Nov. 30 - Dec. 3. For more information, contact Zero to Three - NTI, P.O. Box 7270, McLean, VA 22106-7270; phone (703) 356-8300, fax (703) 790-7237.
- ***Teen Sexuality: Realistic Approaches, Positive Messages*** is the title of the 15th anniversary Advocates for Youth conference to be held Dec. 8 and 9 in Washington, DC. The conference will focus on new research and programming in adolescent sexuality including advocacy, pregnancy prevention, STD and HIV/AIDS prevention, sexuality education, condom availability and peer education. For more information, contact Advocates for Youth, Suite 200, 1025 Vermont Ave., NW, Washington, DC 20005; (202) 347-5700.

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Learning

from page 1

time without learning things we hope they will learn," says Keith Nelson, PhD, of Pennsylvania State University. "In highly favorable learning conditions, the child will learn on the basis of just a few examples."

If the conditions are right, for example, teaching the passive verb structure in English might only require a few demonstration sentences: *The game was won. The cat was chased by the dog.*

"Literally six or seven years of a child's life could pass by and the child will fail to acquire the structure of the passage because the learning conditions aren't good," says Nelson, who, with Perkins and Mark Lepper of Stanford University, is working on a book on the rare events perspective.

Of the hundreds of learning opportunities that pass through a classroom, very few of them stick. Why? Learning requires what Nelson calls a "tricky mix" of ingredients, such as the presence of a challenge, learner motivation and connection with the teacher. Other, more subtle, factors, such as lack of feedback, can undermine a child's capacity for learning.

"What often happens over a few weeks of classroom instruction is that unsuccessful learners have failed to process even a handful of facilitating events," Nelson says. "In contrast, successful learners have selected excellent learning opportunities out of a great many episodic events."

The impact of these relatively rare, but thoroughly processed, events has been documented not only for language, but also for mathematics, art and scientific reasoning.

"To me, the rare events perspective has brought into focus how very fragile the learning process is, how easily it can be derailed," Perkins says. "The rare events perspective does not so much run contrary to anything as it amplifies the urgency of the problem of how learning happens, and how to encourage it to happen regularly."

Perkins and his colleagues are trying to draw up a recipe for the tricky mix that will make learning opportunities more palatable for kids.

"The rare events perspective does not so much run contrary to anything, as it amplifies the urgency of the problem of how learning happens and how to encourage it to happen regularly."

— David Perkins, PhD, Harvard University

It's not news that the motivated learner learns. "This is a very dispositional enterprise," Perkins says. "It's a matter of mindset, attitude, of the disposition to learn and to invest oneself in learning." Empirical evidence shows a link between temperament and cognition.

"In fact, if I had to choose, I would choose to try to create a dispositionally oriented culture of learning rather than teach a whole bunch of learning strategies," Perkins says. "But you don't have to choose: You can do both."

Learner motivation is just one part of the tricky mix. "If we have a child who is a very active learner, and a teacher who is very good at monitoring and very patient at waiting for the teachable moment, then you learn something about how to set this (mix) up," Nelson adds.

"Learning basically is a question of match" between learner and environment, Perkins says. "If there's good match between where the student is (in learning) a particular performance and the supportiveness of the surrounding, one can make it all the way through those (learning) steps."

Sometimes chance matches up the right learner with the right environment at the right time — as when a young artist blossoms under the tutelage of a mentor. But that doesn't mean that schools have to rely on destiny to provide the magic mix. "Match can come about in a teacher-mediated way," Perkins says. "Teachers can work to align the student's backgrounds, attitudes and interests with what's being taught and how it's being presented."

If learning is rare, then maybe the entire educational system should be rethought, Perkins suggests. "It's a matter of thinking more carefully about what we teach and whether it's worth knowing and what it's worth knowing for," he says. ■

For more information on the rare events perspective on learning, you can write to Keith Nelson at the Department of Psychology, Pennsylvania State University, University Park, PA 16802.

▶ Learning is often rare — but not always. The human capacity for episodic memory enables us to retain all sorts of knowledge — what we had for breakfast, a colleague's comment in last week's staff meeting, an interesting fact gleaned from the Sunday paper. There are also times when people learn complex information at an incredibly rapid rate. During language acquisition, for example, a child can master as many as 30 new vocabulary words a day.

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Clinton calls for tobacco ad restrictions

Saying that cigarettes and smokeless tobacco are "harmful, highly addictive and aggressively marketed to our young people," President Clinton launched his effort to "restrict sharply the advertising, promotion, distribution and marketing of cigarettes to teenagers."

As instructed in the president's Aug. 10 remarks, the federal Food and Drug Administration (FDA) posted its intent to regulate nicotine as an addictive drug, as it relates to youth. A 90-day public comment period is now underway.

The proposed regulations are to:

- Require the tobacco industry to spend at least $150 million per year to support an anti-smoking educational campaign directed at children.
- Prohibit cigarette sales to those under 18 and require vendors to check photo identification as proof of age.
- Prohibit vending machine and mail order sales, as well as the sale of individual cigarettes or packs of 20 or fewer cigarettes.
- Prohibit the sale or giving away of promotional items with brand names or logos to children.
- Permit only black and white text advertising in publications with more than 15 percent readership under 18, or more than 2 million young readers.
- Prohibit outdoor advertising within 1,000 feet of schools and playgrounds. Permit only black and white text advertising for all other outdoor ads and ads at the point of sale.
- Prohibit brand-name sponsorship of sporting or entertainment events, but permit the use of company names.

SAMHSA seeks comments on high-risk youth study

As part of an evaluation of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) High-Risk Youth demonstration program, the agency is seeking public comments on the necessity of and parameters for the review.

SAMHSA expects to evaluate 50 projects to assess their effectiveness in preventing or reducing substance abuse among young people, according to a July 26 Federal Register announcement. Comments are invited on the practical utility of the information to be collected; the accuracy of SAMHSA's estimate of the extent of research involved; ways to improve the quality of the data to be collected; and ways to minimize the burden of the information-gathering process on respondents.

The High-Risk Youth program is one of many substance abuse demonstration programs threatened in the present congressional budget debate; the House has targeted demonstration funding in its attempt to slash the SAMHSA budget.

Comments should be received no later than Sept. 23. Send comments to Deborah Trunzo, SAMHSA Reports Clearing Officer, Room 16-105, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857.

Court orders adolescent center to end abuses

Citing a "trail of broken promises," a federal judge this month ordered Alabama officials to put an end to abuses in the state's only secure residential treatment center for adolescents. While there have been previous court decisions concerning the treatment of youths in juvenile-justice settings, this appears to be the first federal court order directly addressing abuses at a children's psychiatric institution.

A preliminary injunction filed in July against the state Department of Mental Health and Mental Retardation for abuses at the Eufaula Adolescent Center in rural southeast Alabama requires the department to submit a plan "to address and resolve immediately the severe and pervasive safety problems and abuse of resident children" at the facility.

U.S. District Judge Myron H. Thompson found evidence of pervasive sexual abuse, gang activity and physical violence by staff against the center's 60 adolescent residents.

With a physical plant described as spartan and outdated, the residential treatment center evolved during the 1980s into a penal facility for antisocial adolescents and conduct-disorder patients. because the center was a secure facility, it became a convenient alternative to a training school.

Reported by William Kanapaux, associate editor of *Mental Health Weekly*, a sister publication of the *Brown University Child and Adolescent Behavior Letter*. For a free sample issue of *Mental Health Weekly*, call 1-800-333-7771.

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Teach your child how, not what, to think: A cognitive approach to behavior

by Myrna B. Shure, Ph.D.

We have many ways of changing the poor behavior of young children. We can tell them what to do and what not to do. We can explain why our idea is a good one. We can model, coach or ignore and hope that what they do will go away. But these approaches are essentially the same — we are doing the thinking for children.

"Interpersonal Cognitive Problem Solving" (ICPS) is different. We introduce problem solving techniques to children. We do not teach children what to think or do, but how to think so they can resolve problems successfully with peers and authority figures. Also known as "I Can Problem Solve," the program teaches children about how they and other children feel and offers options for reaching their goals.

We have learned that as early as age four, children who can think about their own and others' feelings, consequences of actions, and alternative ways to solve problems show fewer behavior problems than in youngsters who don't think but merely react to the immediate moment. Two decades of research indicate that ICPS-competent children of various ages and IQ levels have significant advantages. These children are:

- ❒ less easily frustrated;
- ❒ less likely to lose their tempers;
- ❒ less impatient;
- ❒ less socially withdrawn;
- ❒ more caring about others;
- ❒ more likely to share and take turns; and
- ❒ better able to make friends than other children.

For preschoolers, lesson based games teach early language concepts that can set the stage for later problem solving. The words SAME and DIFFERENT can help children recognize that hitting and kicking are the same because they can both hurt someone and then helps them think of something different to do. Children then learn that different people feel differently about the same thing, that feelings change and that we learn about feelings by watching, listening, and asking.

After learning other problem solving concepts, children are ready for games and dialogues that teach solutions and consequential thinking skills, using their own and others' feelings. They learn that if one solution doesn't work, or is not a good idea, it is possible to try a different way. Most importantly, teachers and parents are taught ICPS "dialoguing," a problem solving communication style.

What you can do

For example, Cheryl's teacher talked to her this way:

Teacher: What happened? What's the matter?

Cheryl: It's mine!

Teacher: What happened when you grabbed the clay?

Cheryl: She hit me.

Teacher: How do you think Vicki feels when you grab from her?

Cheryl: Mad, but I don't care. It's mine!

Teacher: How did you feel when Vicki hit you?

Cheryl: Mad.

Teacher: Grabbing is one thing you can do. Can you think of something different you can do so she won't hit you, and you both won't be mad?

C (to V): Can I have the clay?

Vicki: NO!

Teacher: You'll have to think of a DIFFERENT, new idea.

Continued on next page . . .

. . . Continued from previous page

C (to V): If you let me have the clay, I'll build you a castle. Do you like that?

Happy with their own solution, the children felt proud and the teacher didn't have to explain why children should share. However, this should not be taken to mean that children always should end up with what they want. Good problem solvers can cope better with disappointment, too.

One ICPS teacher told Johnny v couldn't have playdough at an inconv time and asked, "Can you think of something different to do now while you wait?" This child thought for a moment, then shouted happily, "I'll go paint." If the teacher had simply said "I can't help you now, why don't you go paint?" the child probably would have whined, "I don't want to paint, I want the playdough."

In addition to negotiating for what they want, children also should learn to cope with the frustration of not always getting what they want. One mother, who used to yell at her child for interrupting her on the phone, tried asking, "Can I talk to you and to my friend at the same time?" And her child, whose previous reaction was to threw a tantrum, said, "No, and I can think of something different to do."

Our research has shown that parents can teach ICPS skills to their young children, and that impulsive children become less impotient, less over-emotional, and less aggressive. Withdrawn children learn to express their feelings and stand up for their rights.

Dr. Shure is the author of "I Can Problem Solve: An Interpersonal Cognitive Problem Solving Program," and *Raising a Thinking Child: Help Your Young Child Learn to Resolve Everyday Conflicts and Get Along with Others*, New York: Henry Holt, 1994. To order, call (800) 488-5233.

Let your child do the thinking

Here are two examples of how parents often prevent their children from thinking for themselves, by doing the thinking for them.

Scenario 1:		*Scenario 2:*	
Tracy:	Mommy, he hit me!	**Kelly:**	Mommy, he hit me!
Mother:	Hit him back.	**Mother:**	The next time he does that, tell the teacher.
Child:	But I'm afraid.	**Child:**	But he'll call me a tattletale.
Mother:	If you don't hit him back, kids will keep on hitting you.	**Mother:**	If you don't tell the teacher, kids will keep on hitting you.
Child:	OK.	**Child:**	OK.

Different advice, but the same approach. In the first scenario, the child no longer has to think about what to do, since his mother has decided for him. In the second case, the child arranges to have the problem handled for him, by the teacher.

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Prepared by Mary-Kim Arnold, editorial assistant.

Keep Your Eye On

... rising suicide rates among youth.

The rate of children, especially black males, who kill themselves has soared since the 1980s, according to reports from the Centers for Disease Control and Prevention (CDC).

The overall suicide rate of young people under 25 has remained close to 5.5 per 100,000 since 1980. In 1992, 5,007 children, teens and young adults committed suicide.

Young white males continued to have the highest rate overall, growing about 5 percent — from 15.4 in 1980 to 16.1 in 1992.

But the increase was sharpest among all black males. The overall rate in that category rose 20 percent — from 8.5 per 100,000 in 1980 to 10.1 in 1992 — while the rate among black males ages 10 to 14 soared 300 percent, from about 0.5 to about 2.

The rate rose 120 percent among all 10- to 14-year-olds — from 0.8 per 100,000 to 1.7 — from 1980 to 1992. For all 15- to 19-year-olds the rate rose 28.3 percent, from, 8.5 to 10.9.

The CDC said more than 50 percent of those under 25 who kill themselves do so with a gun. While suicides have increased among younger children, suicide *attempts* have not, says the CDC. Children are choosing guns because they work. You may call the CDC at (404) 332-4555.

... depressed moms' effect on boys' IQ.

A recent British study found that development of young boys' intelligence is affected if their mothers suffered from depression during the child's first year of life. Psychiatrist Deborah Sharp, MD, surveyed 250 women in south London and found 33 percent had some form of mental illness, mostly depression, in the first year after birth. When she tested their children at 4 years of age, she found the boys of mothers who had been depressed had significantly lower IQs than the girls of depressed mothers. There was no difference in IQ between boys and girls of mothers who had been depressed *after* the first year after birth. (Reuters)

... unhealthy youth.

The health of America's youth is going downhill, spurred by violence, pregnancy and drug and alcohol abuse, according to researchers at Johns Hopkins School of Medicine. Their report states:

- One of four children ages 10 to 16 surveyed in 1993 reported being assaulted or abused within the previous year.
- Among suburban teens in Colorado and Ohio, 14 percent of girls and 44 percent of boys reported being hit or punched at school.
- Being a victim of sexual abuse or assault is linked to higher rates of alcohol use, sexual promiscuity and other risky behaviors.

(Journal of the American Medical Association, June 7, 1995)

... driving privileges as leverage.

Virginia Gov. George Allen has come up with an idea to get teenagers more motivated to study — deny them driver's licenses if they fail rigorous new standardized tests.

"One thing that is a motivating factor for teenagers," Allen says, "is getting those wheels. I certainly think that's an idea worthy of examining and considering." If his administration determines the idea is legal and practical, Allen will submit legislation during the next session of the state legislature.

At least a dozen states, including Virginia, deny driving privileges to dropouts, but no state has a "pass to drive" law.

And in similar action, Oregon legislators are using driving privileges to help curb violence among older teens. The Oregon House passed a bill that would take away the driver's licenses of students who bring guns to school or turn violent. "We are going to hit them where it hurts," says Rep. Chuck Carpenter, a Republican from Portland, one of the bill's sponsors. (*School Board News*, July 25, 1995. *American School Board Journal*, July 1995)

... leading causes of child death.

The U.S. Advisory Board on Child Abuse and Neglect, concluding a two-and-a-half year nationwide study that included public hearings in 10 states, found a level of fatal child maltreatment far greater than even experts in the field had realized. The report, "A Nation's Shame: Fatal Child Abuse and Neglect in the United States," found that violence aimed at young children has reached public health crisis proportions, claiming the lives of at least 2,000 annually and injuring some 140,000 others. It is the most comprehensive study ever undertaken of child deaths at the hands of parents or caretakers.

The report noted that the child protective system has largely failed to protect children, describing a dismal scenario of underreported child abuse fatalities; poorly trained investigators, prosecutors, and medical professionals; inconsistent autopsy practices, and a public that continues to regard child deaths as "rare curiosities." To obtain a copy of the report ($19), contact the Supt. of Documents, P.O.B. 371954, Pittsburgh, PA 15250-7954, (202) 512-1800. (*Youth Law News*, March-April 1995)

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WHAT'S NEW IN RESEARCH

Expectations influence outcome for neonates

Premature infants judged to be capable of living by obstetricians were 18 times more likely to survive than those considered beyond hope, according to researchers who say judgments of viability tend to determine care during labor and thus influence outcome. A second study finds that maternal race, prenatal care and insurance status may influence the likelihood that very low-birthweight infants will have access to neonatal intensive care. Interventions to improve perinatal referrals should address individual and systemic barriers to the timely referral of high-risk mothers, the authors recommend.

"Obstetrical Judgments of Viability and Perinatal Survival of Extremely Low Birthweight Infants," M. Lynne Reuss, MD, MPH, et al., *American Journal of Public Health*, 85(3):362-366, 1995. For reprints, contact Reuss, Columbia University, New York, NY.

"Access to Neonatal Intensive Care for Low-Birthweight Infants: The Role of Maternal Characteristics," Janet Bronstein, PhD, et al. *American Journal of Public Health*, 85(3):357-361, 1995.

Study casts harsh light on nation's child care quality

A major national study on the quality of the nation's child care centers indicates that one in eight centers provides such poor quality care that the health and safety of children are threatened, and fewer than two of 10 centers provide developmentally appropriate care. The most serious concerns were about the poor care available for infants and toddlers in four of every 10 centers.

The researchers, who teamed from four universities for the $1 million, two-and-a-half year study, concluded that, given the strong national commitment to ensuring that every child enters school ready to learn by the year 2000, the country must commit itself to improving the quality of child care and access to good programs. Furthermore, parents need to have better tools to identify good centers, and states should legislate higher child-care standards.

"Cost, Quality, and Child Outcomes in Child Care Centers," Suzanne Helburn, et al. For reprints, contact Cost and Quality study, Campus Box 159, P.O. Box 173364, Denver, CO 80217. (Executive summary, 20 pages, $8; 90 page public report, $15; 400-page technical report, $40.)

Girls at greater risk of depression than boys

Adolescent girls might be at increased risk for depression because they have lower self-worth than boys and they place a high value on social relationships. According to recent research, by adolescence, the rate of depression in girls is about twice that of boys.

Researchers conducted two studies to examine the contribution of the risk factors of attributional style, perceived self-worth, sociotropy, and social support to the prediction of depressive symptoms in girls versus boys.

Girls reported significantly lower perceived self-worth than boys. Perceived self-worth measured during sixth grade significantly predicted depressive symptoms in seventh grade for girls but not boys. Among girls with high levels of stress, low levels of maternal support also significantly predicted higher levels of depressive symptoms.

In the second study of more than 500 children in grades five and six, the researchers found that girls reported significantly higher levels of sociotropy than boys. Among girls who reported high levels of peer hassles, those who were high on sociotropy had higher levels of depressive symptoms.

As young girls negotiate their way through the normal demands of this age period, those who encounter life events that challenge their already fragile sense of self-worth or the security of their overvalued interpersonal relationships will be particularly vulnerable to becoming distressed, say the researchers.

"Stress and Depression: Risk and Protective Factors in Girls versus Boys," J. Garber, PhD, et al., presented in poster session at the American Academy of Child and Adolescent Psychiatry, 1994. For reprints, contact Dr. Garber at Box 512 Peabody, Vanderbilt University, Nashville, TN 37203.

Urinary catecholamines in ADHD with anxiety

Children with attention-deficit hyperactivity disorder (ADHD) may have a higher tonic activity of the noradrenergic system than control subjects, while children with ADHD and comorbid overanxious (ANX) disorder may be differentiated from those with ADHD alone by higher adrenergic activity, according to recent findings.

Researchers studied children with and without a comorbid overanxious (ANX) disorder and compared them to each other and to normal controls in terms of two hour urinary excretion of norepinephrine, epinephrine and their metabolites. All subjects performed a fixed series of mentally stressful tasks during the collection period. Results showed that children with ADHD, regardless of comorbid anxiety, excreted more normetanephrine, the chief extracellular metabolite of norepinephrine, than controls, as well as more vanillylmandelic acid. Children with ADHD/ANX excreted more epinephrine than ADHD children without anxiety.

"Urinary Catecholamines in attention deficit hyperactivity disorder children with and without anxiety," S. R. Pliszka, MD, et al., presented in poster session at the American Academy of Child and Adolescent Psychiatry, 1994. For reprints, contact Dr. Pliszka at UTHSCSA, Dept. of Psychiatry, 7703 Floyd Curl Drive, San Antonio, TX 78284.

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Resources

- The Asia for Kids catalog is now available with more than 150 books, cassette tapes, crafts, videotapes and ethnic dolls to help children learn the languages and cultures of Japan, China and Korea, and to foster understanding between cultures. **Cost:** Free. **Contact:** 1-800-765-5885.
- The National Organization of Single Mothers (NOSM) was founded in 1991 to help the country's 12 million single parents meet the challenges of daily life. NOSM members receive the organization's news journal, *SingleMOTHER*, six times a year. It offers practical information on parenting, self-help, money and time management, coping with co-parenting and ex-spouses, child support, custody, new books, resources and services. The organization also seeks to counter negative stereotypes of single parents. **Cost:** $1 postage and handling. **Contact:** NOSM, P.O. Box 68, Midland, NC 28107; phone (704) 888-5437, fax (704) 888-1742.
- The CDC has available an order form for baby bottle tooth decay education materials for the Native American community. The materials include posters, public service announcements, stickers, and information fliers. **Cost:** Free. **Contact:** Dental Disease Prevention Activity, Center for Prevention Services, Centers for Disease Control, 1600 Clifton Road, Freeway Park, Room 424, Atlanta, GA 30333; (404) 329-1830.

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Speaking of Books

Meaningful Differences: Everyday Experience of Young American Children
Betty Har and Todd R. Risley (foreword by Lois Bloom)
Baltimore, MD: Paul H. Brookes
268 pages, $22 (hard), 1995
To order, call 1-800-638-3775

Controversial interpretations of the "bell curve" distribution of intelligence, and current rumblings over the efficacy of welfare programs, are met by the timely publication of this volume, based on 30 years of collaborative work on preschool intervention programs in lower socioeconomic neighborhoods in Kansas City. One reviewer says: "This book represents ... a counterpunch to those who would have us believe that a child's destiny is mostly in his or her genes." The volume establishes a scientifically substantiated link between children's early family experience and later intellectual growth, "a link that exists regardless of a child's race." The authors' studies reveal profound effects of the environment on development.

The Vulnerable Child (vol. 2)
T.B. Cohen, M.H. Etezady and B.L. Pacella, Editors
Madison, CT: International Universities Press
231 pages, $35 (hard), 1995
To order, call 1-800-835-3487

A book of chapters about the lives of children at risk for psychopathology. Topics of interest for clinicians include violence, child abuse, survival and vulnerabilities of preschool children of adolescent mothers.

Children's Understanding of Disability
Ann Lewis
New York: Routledge
203 pages, $17 (soft), 1995
To order, call 1-800-634-7064
Written by a British senior lecturer in education, this book promotes debate on the integration of children with learning disabilities into mainstream schooling, and examines ways in which learning-impaired and normal school children interact. Her conclusion: "Carefully monitored inclusion is a feasible, reasonable and mutually beneficial goal."

Stirring the Chalkdust: Tales of Teachers Changing Classroom Practice
Patricia A. Wasley
(foreword by Seymour Sarason)
New York: Teachers College Press
233 pages, (soft), 1994
Theodore Sizer, chairman of the Coalition of Essential Schools, says: "Schools will change when and only if teachers change. Patricia Wasley has wonderfully captured the voices and experience of several veteran and highly respected teachers who turned away from that with which they were comfortable to bolder, more demanding, riskier and promising forms of teaching. There is poignancy here in the swirling, reforming chalkdust, and courage and hope that the rebirth of America's public schools can in fact and against all odds happen." This is a book for all educators, about state-of-the-art teaching, and state-of-the-art evaluation of the efficacy of one's teaching.

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COMMENTARY

The complex origins of violence

Recent advances in genetic research have led many to believe that some persons may be born with certain types of mental and behavior disorders. Sons of alcoholic fathers, for example, might be hereditarily at risk for becoming alcoholics themselves. Such sons adopted immediately at birth have a 25 percent chance of becoming alcoholic, four times more likely than sons of non-alcoholics. But while there is a pattern, no single gene is known to dispose a person to alcoholism. Some curious pathways may yet be found by which the transmission is as environmentally determined as genetically.

Environmental factors including life events such as stress, family conditions, learned coping styles, and cultural factors, according to University of Pittsburgh researchers, interact with genetic dispositions to jointly determine developmental outcomes. Abnormally low levels of a particular neurotransmitter have been found in the blood of college-age sons of alcoholics. Such individuals were found to "feel better" with higher dosages of alcohol. Moreover, their neurotransmitter levels normalized upon increased drinking. With such reinforcements for drinking, addiction is probably more likely.

Conduct disorders may originate in the same way. A genetic disposition, or some perinatal stress causing minimal brain dysfunction, may place the child at risk. The environment then further exacerbates the disposition. Engaging in violence releases extraordinary amounts of opioids into the bloodstream of some predisposed individuals. This can reinforce the person for engaging in such activity and also further instigate such activity. Interestingly, it is the *experience* that changes the body chemicals. Sometimes the organism leads; sometimes it follows. Nature and nurture are constantly in negotiation.

Parent-child concordances are found in serotonin, a neurotransmitter associated with aggression and impulsivity, and sociopaths (persons poorly socialized and inclined toward immoral, non-caring behavior) have deviant serotonin regulation systems. Not everyone with odd levels of chemicals known to be associated with violence becomes violent. Many people without any chemical imbalance, moreover, behave violently. Thus, violence involves both biological and environmental factors, and all one's learning and other experiences, as well as temperament, mediate through the neurohormonal system.

It is one thing to be disposed to behave in a certain way, and it is another to actually behave in that way. Two adult sons of an alcoholic may be disposed genetically, but only one may become an excessive drinker. It is ultimately the behavior that is critical. If an individual is violence-prone but does not engage in such behavior, the violent disposition is of little consequence. Indeed some human development theorists (Freud included) believe that all humans are violence-prone but do not act on their anger because of socialization and learned constraints. The individual's behavioral functioning is, after all, the overriding consideration rather than the serotonin level or genetic disposition. Assessment and evaluation of *behavioral* risk is required for effective intervention.

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Vol. 11, No. 9 September 1995

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Infant disorders help evaluators map crossroads of genetics and behavior

By Carole Samango-Sprouse, EdD

Assessment

The infant with a genetic disorder provides a unique opportunity to evaluate the relationship between brain function, the specific genetic disorder and neurodevelopmental performance. The evaluation process enables interventionists a window to more fully understand how the brain and behavior interrelate.

It used to be said that genetics is only a part of medicine; now, many believe genetics *is* medicine. To many professionals, the value of the diagnosis of a genetic disorder in infant assessment is not yet well-appreciated.

In the new millennium, the impact of the etiology and the genetics of particular syndromes will be profound. With the new technology of genetic analysis, linkage studies and neuroimaging techniques such as magnetic resonance imaging (MRI), our ability to understand the central nervous system and subsequent infant behavior will improve dramatically.

Infant interventionists now recognize that each infant is a complex, interactive and dynamic being who shapes and changes both the environment and parental behavior. Infant development is often described as a

(turn to 2)

Girlhood is more bitter than sweet

Adolescence

The choice of self — a developmental task of adolescence — is a precarious situation for girls caught between the push of their needs and the pull of the culture.

"Today's girls come of age in a dangerous, sexualized media-saturated culture," says clinical psychologist Mary Pipher, PhD. "They are pressured to be beautiful and sophisticated, which is defined by peer culture as rejecting parental values, smoking, using chemicals and being sexually active."

Pipher says her Lincoln, NE, office has been "swamped" with adolescent girls as clients. They come with serious problems: self-mutilation, suicide attempts, sexual assault, alcoholism, eating disorders. (For her advice on therapy with adolescent girls, see box, page 4.)

"In the 1990s, there are new pressures that parents and other adults often do not understand," says Pipher, who describes what her life was like growing up in Beaver City, NE, population: 420. "There were no drugs in my town. There was no pornography. There was no alcohol sold in town; we had eight churches and no liquor stores. And we had a lot of blue laws. A serious discussion was whether or not it was a sin to mow your yard on Sunday."

This Rockwellian picture of girlhood seems quaint by today's standards, and Pipher quickly discov-

(turn to 4)

This month's client handout: Helping the child who just doesn't seem to fit in

Infant disorders

from page 1

function of numerous influences, including genotype, phenotype and environtype. Therefore, the nuances of an infant's behavior must be understood and evaluated within the context of the genetic disorder.

With increased attention and recognition to the influence of etiology, various behavioral phenotypes in children are being described. Each infant pattern of neurobehavioral organization and competencies requires a different developmental intervention plan to optimize development.

For example, Williams syndrome, a chromosomal disorder characterized by an extra chromosome 7 in all cells of the body, has several characteristic features that must be considered in the evaluation process. Many infants with Williams syndrome demonstrate frenetic, disorganized movements with significant hypersensitivity to sound, movement and most forms of stimulation. For these infants, graded, well-controlled, but limited, sensory stimulation should be used to obtain optimal test results.

In contrast, the infant with Prader-Willi, an abnormality of chromosome 15, has severe truncal hypotonia and minimal responsiveness to most stimulation. The examiner must exert tremendous creativity to optimize the performance of an infant with Prader-Willi syndrome. The examiner often swaddles the infant into a very snug bunting to minimize the effect of the truncal hypotonia, using an upright position to foster alertness and repetitive movement to elicit an alert state. With these maneuvers, the infant demonstrates promising neurobehavioral competencies during the newborn evaluation.

The etiology of each genetic syndrome influences the brain infrastructure, the behavior and, eventually, the intellectual outcome of the infant. With increasing knowledge of the individuality of the neurodevelopmental and neurobehavioral competencies of each syndrome, the opportunity to conduct more appropriate and more individualized assessments and intervention is possible.

A basic tenet of infant assessment must be the recognition of the intimate relationship between the medical etiology and the developmental outcome. By not recognizing or understanding the genetic syndrome, it is quite possible that characteristic behaviors of the specific disorder are misinterpreted or misunderstood. For instance, children with Fragile X syndrome, the most common cause of mental retardation in boys, display autistic-like behavior. New research findings suggest that, for most of these children, the autistic-like behaviors are actually related to anxiety in social situations. The diagnosis of this genetic disorder and the etiology of the behaviors change the intervention strategies used by the therapists and the child's family.

The art of the assessment of the infant with a genetic disorder is a melding of the scientific, medical and developmental characteristics of the syndrome while retaining the critical fact that each infant is a unique individual. The information delivered to families must be given in three distinct ways:

- The results should describe the infant's strengths and weaknesses demonstrated during the testing and within the family context.
- The infant's performance should be described in relationship to the characteristic behaviors of the syndrome.
- The infant's neurobehavioral organization must be viewed in comparison to the non-handicapped population.

In this manner, parents are given a comprehensive picture of their infant's behavior. The evaluation process recognizes the uniqueness of the infant and the contribution of the family's genetic makeup. Simultaneously, the impact of the genetic etiology on behavior and infant development is also identified and described to parents. Without the recognition of the etiology of the genetic syndrome, a profound influence on the infant's behavior, the family's functioning and the eventual outcome of the infant's development is neglected.

Infant interventionists recognize now that each infant is a complex, interactive and dynamic being who shapes and changes both the environment and parental behavior.

With further studies of large populations of infants with specific syndromes and the behavioral phenotypes, an increased understanding of learning, central nervous development and behavioral development will be available to all of us. This knowledge will increase our understanding of infants with specific genetic disorders and their unique capacities, the influence of genetic makeup on the behavior competencies of infants, and maybe even of the evolution of development for all infants. ■

Carole Samango-Sprouse is director of infant and child studies at Children's National Medical Center. You can write to her at the Department of Medical Genetics, Children's Hospital, 111 Michigan Ave., NW, Washington, DC 20010-2970.

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Does your child just not fit in? You can help!

by Marshall P. Duke, Ph.D., and Stephen Nowicki, Ph.D.

Does your child sometimes seem unable to "get it right?" No matter how hard they try, some children simply don't fit in with their peers. They really want others to like them, but the harder they try, the worse they seem to do. They are the last ones picked for teams, the ones who sit alone in a corner of the playground, wondering why others don't like them.

Many of these children who want so badly to belong — but somehow are failing to develop the kinds of friendships so necessary to be happy and well-adjusted — may be suffering from what we call "dyssemia."

"Dyssemia" is a term that describes a difficulty in the use of nonverbal signs [*dys-* = difficulty; *-semia* = signs]. This communication deficit is a sort of body language version of *dyslexia* [difficulty reading] that prevents children from interacting with others in positive ways.

Nonverbal communication is key

Nonverbal communication — the ways in which a child uses rhythm and time, personal space, gestures, postures, facial expressions, tone and loudness of voice, and dress and hygiene — often is the key to whether or not children fit in with their peers.

Children can suffer from some form or combination of nonverbal language deficit. An expressive deficit means that they cannot transmit the customary nonverbal signs, whereas a receptive deficit means that they cannot read nonverbal indicators necessary for successful interpersonal relationships.

Compared to verbal communication, nonverbal communication is more continuous, more out of awareness, more likely to be believed by others, and more involved with emotion. For this reason, dyssemia can have a serious negative impact on relating to others.

Peer groups serve important function

Dyssemia comes about because children do not have access to appropriate situations and experiences necessary to learn the particular nonverbal skills. This may happen to children who spend all their time with adults, for example, and therefore have limited access to their peer group.

Also, the emotional impact of traumatic events — such as parents' divorce or the death of a close relative — can hinder the learning of appropriate nonverbal communication and cause dyssemia to develop. The good news, however, is that since most nonverbal social processing deficits are learned and become habituated, these problems can be changed if they are identified.

It is important to remember that children who simply tend to favor one or two close relationships over the "popular kids" at school don't necessarily have dyssemia. If your child is able to develop and maintain successful friendships with other children, the choice to play independently or with only one or two other children probably is more indicative of individual personality than a dyssemia. However, if you feel that your child is one who does not quite "fit in," and is unable to have any positive peer

Continued . . .

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relationships, look for the following indicators of a dyssemia. The child often:

- ❒ is described by teachers and others as tactless and insensitive;
- ❒ is labeled by other children as "dumb," but has average or above average intelligence;
- ❒ is seen as lacking in social maturity;
- ❒ has difficulty perceiving danger;
- ❒ has difficulty understanding rules and sequences of games;
- ❒ has difficulty recognizing the connection between his or her behavior and its consequences;
- ❒ feels sad, bewildered, lonely, confused or anxious, or different;
- ❒ perseveres in activity even when it leads to punishment or failure; or
- ❒ is accurate in one form of verbal communication one day but not the next.

If your child exhibits five or more of these indicators, it is possible that he or she has a dyssemia. Talk to your child's school counselor or your therapist, who can make a referral to a specialist in child psychology.

In the meantime, you can help your child develop more effective nonverbal communication skills by practicing the following exercises:

- ➢ Watch television with your child, but alternate between having the sound and the picture turned off. Ask your child to interpret the emotions being communicated.
- ➢ Have informal discussions with your child about the nonverbal behaviors of people observed in shopping malls or children on playgrounds. See whether they can assess the communications of others.

The treatment process for dyssemias usually consists of three steps: 1) awareness — the child is encouraged to recognize that there is a problem, and the treatment is explained; 2) practice — verbalization and expression skills are repeated until the nonverbal skill is learned; and 3) application — the child is monitored for progress in applying practiced skills in real world situations.

Children's relationships with peers are an important part of their social, emotional, and intellectual development, and often provide models for future adult relationships. As such, it is important that your child have every opportunity to develop good interpersonal skills, both verbal and nonverbal, to help travel the road to happy, healthy adulthood.

Dr. Duke and Dr. Nowicki are faculty members in the psychology department at Emory University in Atlanta, Georgia.

The Brown University Child and Adolescent Behavior Letter

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Prepared by Mary-Kim Arnold, editorial assistant.

Keep Your Eye On

... computerized grading.

A former high school English teacher who developed a computer system to grade essays says it's more objective than human evaluators. Ellis Page, EdD, calls the program Project Essay Grade (PEG), which takes subjective criteria used by human judges and statistically approximates what they would grade an essay. Page, a Duke University professor of educational psychology, says the program uses more than 1,000 variables to arrive at the data used to simulate the human readers. Besides saving time, computers have the advantage of being more objective. "Our program doesn't become tired; it doesn't pay attention to sequence effects, like reading three bad papers in a row and here's one that's all right so you say, 'Gosh, isn't this great?'" Page says. "People become a little less discriminating after they've been scoring papers for four hours." In a blind test last year by the Educational Testing Service of Princeton, NJ, the correlation between PEG's predictions and a pool of human judges was, at 0.9, almost perfect. **Contact:** Ellis Page, EdD, Box 90739, 213 West Duke Building, Durham, NC 27708.

... family size.

The more brothers and sisters children have, the lower their grades, a new nationwide study shows. The results, which include data from 24,599 eighth-graders, suggest that academic achievement drops as families grow because parents have less time and fewer economic resources for each child. As family size increases, parents talk less to each child about school, have lower educational expectations, save less for colleges, and have fewer educational materials available. These are the factors that had the largest effect on grades, according to the study. **See:** *American Sociological Review*, October 1995.

... benefits of touch.

Massaging premature infants significantly increases their weight gain and shortens their hospital stays, Tiffany M. Field, PhD, reported at last month's convention of the American Psychological Association. Normal, full-term infants given massage therapy cry less, are more active and show signs of less stress and depression than similar children who are rocked. Positive effects of massage have also been seen in studies of children with asthma, autism, diabetes, burn injuries, developmental delays, juvenile rheumatoid arthritis, post-traumatic stress disorder, adolescents with conduct and eating disorders and children who have been sexually and physically abused, said Field, director of the Touch Research Institute at the University of Miami. She added that having grandparents and parents give the therapy enhances their own well-being. **Contact:** Tiffany M. Field, PhD, Department of Pediatrics, University of Miami School of Medicine, PO Box 016820, Miami, FL 33101.

... mean mice.

The serendipitous discovery of a strain of highly aggressive mice that are missing the gene that encodes monoamine oxidase A (MAOA) could lead to a fuller understanding of the etiology of violence. In these mice — which were originally developed in a study of gene therapy for HIV infection — norepinephrine concentrations were doubled. In pups, serotonin concentrations were increased up to ninefold, and their behavior included trembling, difficulty in righting and fearfulness. Adult mice manifested a distinct behavior syndrome, including enhanced aggression in males. MAOA, an enzyme that degrades serotonin and norepinephrine, has recently been shown to be associated with aggressive behavior in men of a Dutch family. **See:** *Science*, June 23, 1995.

News Update

- Bribery apparently gets kids moving. Researchers from Ohio State University put dollar bills where children could reach them as they rode an **exercise** bike. Kids who were offered money got their heart rates up to an average of 198 beats per minute; those given only verbal encouragement rode to an average of 186 beats per minute. But regular financial incentives might lose their appeal.
- The reported prevalence of **anencephaly and spina bifida** in the United States has steadily declined as prenatal diagnosis techniques have progressed, according to the Centers for Disease Control and Prevention (CDC). In some areas, the prevalence at birth of anencephaly was reduced by about 60 to 70 percent, and that of spina bifida by about 20 to 30 percent, the CDC says.
- A new study finds that more parents are placing their babies to sleep on their backs and sides to reduce the risk of **sudden infant death syndrome** (SIDS). Researchers from Thomas Jefferson University in Philadelphia surveyed 760 parents and found 59 percent place their infants on their backs or sides to sleep, an increase of more than 20 percent.
- **Mislabeled baby formula** may be on market shelves and would be very difficult to recall in case of an emergency. A seven-month investigation by the federal Food and Drug Administration (FDA) revealed extensive scams to market fake, outdated or mislabeled baby formula, according to *The New York Times*. Government officials believe that all of the counterfeit formula has been removed, but mislabeled formula, which could cause problems for babies with special food restrictions, could still be on the market.

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Girlhood

from page 1

ered that drawing on her own memories was not enough to treat the young women she sees in her office today.

It's not so much that girls have changed, argues Pipher, but that the world around them has. Loss of family and community relationships, the media barrage and the ubiquity of substances and handguns have all contributed to making the '90s a dangerous time to come of age.

"More than a third of all teenagers believe they will die before age 21," says Pipher. "That's pretty incredible, when you think about what that means for their mental health."

Young people are neither emotionally nor cognitively prepared for the hard course they have to steer through adolescence.

"Girls who sleep with stuffed unicorns aren't ready for pressure to be sexual and offers of LSD and chemicals," says Pipher, author of *Reviving Ophelia: Saving the Selves of Adolescent Girls* (in paperback, Ballantine, 1995). "The learning curve is just too steep for them, and their selves go down in the storm."

Their black-and-white thinking, exquisite self-consciousness, extreme egocentrism and emotional reasoning — the frustrating but normal stuff of adolescence — are almost anachronistic in a culture that encourages impulsivity and rebelliousness.

For girls, who seem to leave their vibrancy and confidence with childhood, the passage to adulthood is a time of indoctrination into the woman's role, Pipher says. "When girls are encouraged to restrict their behaviors to a narrow band of what our culture considers acceptable for young women and their real selves tend to go underground, they sacrifice authenticity on the altar of social acceptance," she says.

A large and highly publicized body of research shows that girls change radically when they start junior high: As a group, their IQs drop; their math and science scores plummet; they talk less; they're less curious; they're less tolerant of stress; they're more prone to depression; they're unhappy with their bodies.

"From the vantage point of a seventh-grader, walking the halls of a junior high, listening to the music, watching the movies, listening to what boys and girls around her are saying, reading the magazines, the definition of womanhood that she's seeing is pretty simplistic and degraded," Pipher says.

How a girl navigates around the landmines of adolescence has lifelong implications. "Many women, in a sense, lose part of themselves for years," she says. ■

Working with adolescent girls

Psychologist Mary Pipher, PhD, says her goal in therapy with adolescent girls is to accelerate their emotional and cognitive development. "The world they're living in is so tough, they need those skills as quickly as they can get them," she says.

Pipher concentrates on these three areas:

Intrapersonal skills

Through Socratic questioning, Pipher helps girls define themselves for themselves, without relying on the opinions of others. She asks questions like: Who are you? How do you know what you truly think? Whom do you most respect?

She also teaches the difference between thinking and feeling, and the importance of acting on the basis of rational self-interest.

Other important lessons for girls: Stress management and relaxation, emotional management and self-validation skills.

Interpersonal skills

Girls need to realize that they can make conscious choices about their lives. Pipher teaches them to make position statements, such as: "If you drink any more beer, I won't ride home with you." Simply pleading, "Please don't drink any more beer" doesn't count, says Pipher, who aims to give young women "a strong, assertive, centered position" from which to approach life. She has her clients keep track of their "victories" — instances when they have been able to define and stand by a position.

Girls also need guidance in making wise decisions about sex and substances, choices they can be grappling with as early as sixth grade.

Pipher advises her clients to set guiding principles by asking them to define the conditions under which they would or wouldn't have sex. She also helps them to be strong enough to say no and cope with the teasing and harassment that may come as a consequence.

Perspective skills

Make no bones about it: Junior high is awful for most girls, but it isn't forever. Pipher invites her young clients to "time travel," by getting them to talk about their childhood memories and their adulthood aspirations.

Doing volunteer work is another strategy that exploits the natural idealism of youth to help combat depression and narcissism. The added benefit is it gets girls away from teenagers: Being around old people, for example, will give girls a much different view of the world, Pipher says. ■

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WHAT'S NEW IN RESEARCH

Parenting is more important than family configuration

Parenting style, rather than family composition, seems to be the key determinant of both family functioning and the well-being of adolescents, according to a study of Canadian high school students. The study showed no differences in family functioning or depression scores among adolescents from single-parent, stepparent and intact families.

Adolescents from stepfamilies did, however, report more stress. A total of 801 students were surveyed twice during 10th grade when they were assessed for depression, stress and behavioral problems, as well as their perceptions of parental style and family functioning. In 12th grade, they were assessed again, this time for both social and academic functioning.

One analysis of the data contrasted adolescents living with both natural parents, living with only one parent present (the mother, in most cases), living with one parent elsewhere and a stepparent and natural parent present, and living with neither parent. Not only was there no significant difference in the four groups' perceptions of family functioning, adolescents with a dead or completely absent parent did not perceive greater family dysfunction than peers who regularly saw their non-custodial parent.

Overall, the more caring the parent, the less depressed the adolescent. On the other hand, the more overprotective the parent, the more depressed the adolescent.

While the parenting styles of both mothers and fathers were significant predictors of family function and adolescent well-being, cross-gender effects were found. Boys' well-being was significantly associated with the level of caring they perceived from their mothers, while girls' well-being was associated with their fathers' level of caring.

The findings appear to call for switching the focus of social policy efforts from strengthening the family to strengthening parenting, the researchers suggest.

"Family structure, family functioning and adolescent well-being: the transcendent influence of parental style," Allan H. McFarlane, MD, et al., *Journal of Child Psychology and Psychiatry*, 36(5):847-864, 1995. For reprints, write to Dr. McFarlane, Department of Psychiatry, McMaster University, 1200 Main St. W., Hamilton, Ontario, Canada, L8N 3Z5.

Researchers profile women who kill their children

Although cases of mothers killing their children are relatively rare, a group of psychologists, including Geoffrey R. McKee, PhD, the court-appointed psychologist in the Susan Smith case, found common factors among them. The study described 20 cases of mother-child filicide comprising 26 deaths in which the women were ordered for pre-trial evaluations at a university-based forensic psychiatric hospital. Data collection, which began in 1986, is ongoing, but the emerging portrait is of a woman who:

- Is the biological mother of the victim.
- Is legally married or in a common-law relationship.
- Is mentally ill at the time of the offense.
- Kills a single child less than 25 months old.
- Acts alone in her own home.
- Has no criminal history.
- Is unemployed at the time of the offense.
- Was raised in a two-parent, lower socioeconomic background.
- Has lower-than-average intelligence and educational level.
- Has two or more children in her care.

The fact that most of the victims were toddlers or younger suggests that the women could have been suffering from postpartum or adjustment problems. Although their histories do not depict a pattern of violence, the women presented with multiple life stressors and symptoms of serious mental illness, yet were not seeking treatment at the time of their crimes.

"Characteristics of women who kill their children," Steven J. Shea, PhD, et al., presented at the American Psychological Association convention, August 1995. For reprints, write to Dr. Shea, Forensic Unit, University of South Carolina School of Medicine, Box 202, Columbia, SC 29202.

Depression scale misses ethnic differences

Depression assessment instruments for adolescents aren't as sensitive as they should be to the effects of ethnicity, according to two separate studies. In the first, 1,976 young people from three ethnic groups completed the Centers for Epidemiological Studies-Depression scale (CES-D) and other screening instruments. CES-D scores were highest for African-Americans and lowest for non-Hispanic whites, with Hispanic youth falling in between. Multiple regression analyses showed that ethnic group and gender were significantly correlated with psychopathological scores. The second study, which involved 101 African-American and 198 white adolescents, also found the CES-D inadequate in identifying race differences, although it was much more sensitive to the effect of gender.

"Depressive symptomatology in a tri-ethnic sample of adolescents" and "Race, gender and depressive symptomatology in a high-risk adolescent sample," Andres J. Pumariega, MD, et al, presented at the American Academy of Child and Adolescent Psychiatry meeting, October 1994. For reprints, write to Dr. Pumariega, University of South Carolina School of Medicine, W.S. Hall Psychiatric Institute, 1800 Colonial Drive, Columbia, SC 29202.

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YOUTH VIOLENCE

Adults responsible for most crimes, but juveniles commit more than their share

While the number of people arrested for violent crimes has increased in all age groups, the increase has been disproportionate for juveniles and young adults. According to a U.S. Department of Justice report, the arrest rate for violent crimes — rape, personal robbery and assault — increased nearly 60% among juveniles, compared to 47% for 35- to 39-year-olds. In fact, juveniles were responsible for about one in five violent crimes in 1991.

Seventeen percent of all serious violent crimes in 1991 were committed by juveniles only, either alone (11%) or in groups (6%), the report says. Another 8% of serious violent crimes were committed by a group of offenders that included at least one juvenile and one adult. In all, one-fourth of all serious violent crime involved a juvenile offender; and of these crimes, more than one-half involved a group of offenders.

By the year 2010, the number of juvenile arrests for a violent crime could more than double.

The figures don't put all of the blame on juveniles. Adults were responsible for 70% of the recent increase in violent crimes, but juveniles contributed more than their fair share.

"Large percentage increases can yield relatively small overall changes," the authors of the report explain. "Juvenile arrests represent a relatively small fraction of the total; consequently, a large percentage increase in juvenile arrests does not necessarily translate into a large contribution to overall crime growth."

Nevertheless, the juvenile crime statistics forecast a grim future. If the trend continues as it has for the past 10 years, the authors estimate that by the year 2010, the number of juvenile arrests for a violent crime will more than double, and the number of juvenile arrests for murder will increase nearly 150 percent.

The Office of Juvenile Justice and Delinquency Prevention recommends improved coordination at the federal, state and community levels.

Other findings of the report:

- Juvenile arrests for weapons law violations more than doubled between 1983 and 1992.
- Between 1976 and 1991, 9 in 10 juvenile murderers were male, and about half were white.
- The typical male juvenile homicide offender kills a friend or acquaintance during an argument.
- The typical female juvenile homicide offender is nearly as likely to kill a family member (41%) as a friend or acquaintance (46%).
- Both male and female juvenile killers tend to kill males.
- Young children are often killed by parents, older juveniles by their peers.
- Most juvenile victims know their attacker, usually well.
- Black males ages 14 to 17 are more likely than other juveniles to be homicide victims.
- Homicide victimization rates have increased for both males and females. ■

For a copy of the report, "Juvenile Offenders and Victims: A Focus on Violence," contact the Juvenile Justice Clearinghouse, PO Box 6000, Rockville, MD 20849, (800) 638-8736.

POLICY WATCH

Mental health field sees bleak scenario

Though many questions remain to be answered between now and the Oct. 1 start of the federal fiscal year, mental health advocates are seeing little evidence that Congress will reverse a budget-cutting direction that wounds some of their most coveted programs.

The House Appropriations Committee was expected to follow the recommendations of its Subcommittee on Labor, Health and Human Services and Education; the subcommittee had voted to convert more than $500 million in mental health and substance abuse demonstration funding under the Substance Abuse and Mental Health Services Administration (SAMHSA) to just $145 million in consolidated funds, which would leave mental health and substance abuse programs fighting for a piece of a shrinking pie.

Preserved in the drastic change, however, would be the $60 million children's mental health demonstration. But according to budget analyses from lobbyists in the mental health field, SAMHSA mental health demonstrations that would not survive as separate line items in the House's plans include the Projects to Aid in the Transition from Homelessness (PATH) and Access to Community Care and Effective Services and Supports (ACCESS) programs; community support demonstrations; and clinical training programs.

Sen. Nancy L. Kassebaum (R-KS) has introduced a SAMHSA reauthorization bill calling for significant restructuring of grant programs, but the Senate still has not suggested any fiscal 1996 budget figures. ■

This article originally appeared in *Mental Health Weekly*, a sister publication of *The Brown University Child and Adolescent Behavior Letter.*

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At the Library

Last time, we listed books to help young children deal with bullies. The following books, which are available at most public libraries, will show older elementary school children that others have faced bullies and how they dealt with them.

Joshua T. Bates Takes Charge by Susan Shreve (Knopf, 1993). Grades 3-5. Joshua has survived the "disgrace" of being held back in third grade (*The Flunking of Joshua T. Bates*, Knopf, 1984), but, now that he's in fifth grade, his biggest worry is that he'll be left out. To be included, Tommy Wilhelm has to like you and not consider you N.O. (Nerds Out). When Tommy and his friends label the new kid a nerd, no one wants to get involved. Although malicious and cruel pranks are played on Sean, no one bothers to help him; no one wants to get involved. After much soul-searching (and prodding from his parents and school principal), Joshua realizes he isn't afraid of Tommy, but he is afraid of the power Tommy has over the other kids.

The Secret Life of Hubie Hartzel by Susan Rowan Masters (Lippincott, 1990). Grades 3-7. Hubie Hartzel is a fifth-grader given to daydreaming. He has real-life trouble like a weight problem, a sick cat and the class bully. On top of that, he isn't doing well in school, has a crush on his art teacher, and his best friend is beginning to notice girls. Hubie's father is completely against fighting, believing there are better ways to settle disagreements — even with a bully.

Gopher Takes Heart by Virginia Scribner (Viking, 1993). Grades 3-7. Fifth-grader Gopher hands over his milk money to Fletcher every morning on his way to school. When Gopher's class chooses him to make the perfect valentine for their teacher, Fletcher takes the money for supplies. This is too much for Gopher, who finally stands up to the bully. Despite his hard work, the valentine ends up looking like a "a red-faced lady with doily fans and a bunched-up bow." When the other kids make fun of it, it's Fletcher who comes to Gopher's aid.

The Shorty Society by Sheri Cooper Sinykin (Viking, 1994). Grades 3-7. Three seventh-graders, tired of being called shrimp, shorty and squirt, form a secret club, the Shorty Society. Mild pranks and practical jokes escalate into the "ultimate revenge," but if revenge is supposed to be so sweet, why do they feel like jerks? Are they becoming the bullies now?

Barbara Goldberg, MLS, is a contributing editor to *All Kids Considered*, an independent parenting publication.

Speaking of Books

Medicine and the Family: A Feminist Perspective
Lucy M. Candib
New York: Basic Books, 1995
360 pages, $38, hardcover
To order, call 1-800-331-3761

Drawing on 20 years of experience as a family doctor, the author challenges prevailing assumptions underlying teachings about child and adult development, sexual abuse and the family life cycle. Candib says in her introduction: "Medicine operates under the impression that its theory and practice are gender-neutral. But women, both clinicians and patients, are only too aware that the practice of medicine is gendered in a masculine way. In this book, I talk about how the theory is male-gendered as well."

Resources

Birth control info

A series of tear-off information sheets describes a variety of birth control methods, including implants (Norplant), injections (Depo-Provera), the pill, condoms and foam, the female condom and IUDs in simple language with illustrations. Information sheets are available in English and Spanish. **Cost:** $5.50 for a pad of 50 sheets. **Contact:** Education Programs Associates, 1 W. Campbell Ave., Bldg. D, Campbell, CA 95008, (408) 374-3720.

Early violence prevention

A new book helps early childhood professionals teach children to be assertive, non-violent problem-solvers. In *Early Violence Prevention: Tools for Teachers of Young Children*, Ronald G. Slaby, PhD, and his co-authors describe what is known about the development of violence and implications for classroom practice. **Cost: $7. Contact:** National Association for the Education of Young Children, 1509 16th St., NW, Washington, DC 20036, (800) 424-2460.

Caregivers' scale

A new scale encourages people who care for children or elderly family members to also take better care of themselves. The Caregiver Well-Being Scale, developed by a social worker at St. Louis University, helps caregivers identify areas of their lives where they are doing well, and areas where they might need help. The 45-question, self-administered scale can also provide social workers with information on how to better assist clients caring for family members. **Contact:** Susan Tebb, PhD, School of Social Service, St. Louis University, 3550 Lindell Blvd., St. Louis, MO 63103.

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COMMENTARY

Outpacing our own family legacy

Ideas about what can be expected of children at different ages, and should be required of them at various developmental stages, are based largely on rules laid down by the culture in which the child is reared. The home culture imbues its children with notions of what is permitted and what is not, and those constraints can vary greatly from one society to another and from one historical period to another. In different eras, widely different conceptions of the nature of infancy and childhood have been held.

In some cultures today, it is not considered good adult behavior, or safe for the child, to look into the child's eyes for more than a passing glance for fear of giving the child bad luck. Similarly, 17th and 18th century paintings of children depict them as little adults, and writers often attributed adult-like ideas to children. Indeed, until very recently, children were allowed to — sometimes forced to — work at hard labor, and for longer hours than are tolerated today for adults.

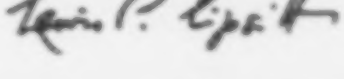
The concept of "development" did not come into full swing until Darwin's *Origin of Species* was published, and the American psychologist G. Stanley Hall explored *The Contents of Children's Minds*, asserting that children's minds are uniquely child-like. In his seminal work on children, Darwin found that infants and young children's emotions bore similarities more with other animals than with the elders of their own species. (He delayed publishing this because, some think, he thought the world was not ready to know or believe it.)

We know much more about children's behavior and mental processes today than we did just 50 years ago, which is but a tiny fraction of the time in which hominids have roamed the earth. Some rather new understandings and expectations of children have arisen. Even the concept of the teen years as "adolescence" is quite new historically, to accommodate that transitional period from childhood to adulthood in which our culture does not require employment and intends children to continue schooling.

Conceptions of infantile, childhood and adolescent states of development are affected by custom, historical trends and transgenerational change, but also by the political and economic context in which youngsters are reared. In the United States, child labor laws now prevent most of the use our society once made of children to enhance family income and the culture's economic welfare.

Paradoxically, today's rapid acceleration of technical innovation, and the increasing intensity of educational pursuits designed to adapt our children to these advances, has led to cognitive and personal isolation of some children from their parents. Children often know more about automobiles, computers, aircraft, electronic music-makers and, alas, weaponry than their elders.

Some adults find this disparity of cognitive apperception scary. It is very different from the days when parents taught the identical skills to their children that their own parents taught them. Those skills were of intergenerational value. Technological advances have made some lessons outmoded by the time parents teach them to *their* children. Psychological or behavior lessons included.



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- spoiled appetites. Drinking sugary beverages before meals may be behind some common complaints.

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- Single mothers don't have as much time to spend with their children, and a professor at the University of Wisconsin's Institute for Research on Poverty hopes that welfare reform won't make the tradeoff worse for kids.

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10 commandments for work with teens

By Clarice J. Kestenbaum, MD

Clinical Issues

Many therapists throw up their hands at the idea of attempting to psychoanalyze teenagers and advise parents to come back next year, when the acute phase of fulminating adolescence has abated. Who can withstand the rapid mood changes, sudden regressive plunges and equally sudden resurgence of health? To get the troubled adolescent back onto the normal developmental track so that functioning is optimal is indeed a formidable task.

There are two basic rules the adolescent patient must follow:

- Show up for sessions.
- Tell the therapist whatever is on his or her mind.

As all therapists who work with adolescents well know, these rules are frequently broken.

But the therapist can abide by the following 10 commandments, which will greatly facilitate treatment:

1. **Do not take sides.**

Avoid the trap of agreeing that the parents are monsters; the therapist may get caught in the splitting.

2. **Do not be overparental.**

The therapist should not be in competition with the parent(s).

3. **Do not be uninvolved or unconcerned.**

Information about self-destructive behavior must be shared with

(turn to 2)

Grief counseling is a family affair

By Alan D. Wolfelt, PhD

Family Systems

If family systems concepts have not been well-integrated into grief counseling practices, part of the reason is that the family has been perceived as separate from the counselor's involvement in the system. The counselor has often been taught to be an observer of, rather than a participant in, the family system.

As leading family therapists have historically emphasized, the central unit in family counseling is not the family alone, but the therapeutic system, which includes both the family and the counselor. A logical starting point for a model of the counselor's role in helping bereaved families, then, is that the counselor is part of the system.

A view of the counseling relationship between the counselor and bereaved child can be referred to as "the illusion of the dyad in grief counseling." Even when they are not physically present in counseling sessions, family members are very much involved in what goes on between the counselor and the bereaved child.

I have found that family members (or guardians with whom the child lives) influence, if not decide on, the selection of the counselor and the expectations the child has of the counseling process. Most also carry out suggested helping prin-

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This month's client handout: What's the best way to keep your kids off drugs?

10 commandments

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parents. Issues of trust are paramount, but sometimes confidentiality can go too far.

4. Do not overidentify with the teenager.

Countertransference problems engendered by envy of the younger, healthier patient can interfere with the therapeutic process.

5. Do not be passive.

Silences are not always golden. The therapist must be active and take stands.

6. Do not be unavailable.

Teenagers need to know they can reach the therapist between sessions.

7. Do not be dishonest.

Adolescents will immediately detect false compliments and false values.

8. Do not be pejorative.

The therapist is there to help the adolescent master skills, increase self-esteem and gain autonomy, not to be critical in the manner of parents and teachers.

9. Do not take symptoms lightly.

Self-esteem and body image problems are of primary concern to a teenager.

10. Do not treat an adolescent if you cannot find something to like about him or her.

Since the adolescent is often in conflict with his or her parents and everything invested with their authority, the parent is devalued. Yet the adolescent still needs parental guidance and control. Despite his or her protestations of independence, the teenager is dependent on parental support. This conflict is often the determining factor in sending an adolescent for treatment.

Assessment of symptoms must be made before undertaking psychotherapy. An evaluation is, of course, a necessary first step. A careful delineation of current symptoms, constitutional predisposition, premorbid history, personality characteristics and level of functioning must be made.

The evaluation includes an initial visit with the parents, which is most successful after seeing the patient several times. During the visit, the therapist not only gathers information about events in the parents' lives, including things that happened before the child was born. The therapist also explains to parents that:

- Information about the patient is a one-way street — *from* the parent *to* the therapist, not vice versa.
- The therapist can judge the family for him- or herself and be of greater help to the patient.
- It is the parent who pays the bills.

Parental involvement is an important adjunct to individual psychotherapy. The therapist may choose to see parents on a regular basis, or refer them to another physician or social worker who will communicate with the teenager's therapist.

The therapist who works with adolescents should also be fully aware of the patients' academic and social functioning. He or she may have to recommend tutors, after-school group activities, college advisers, etc. In other words, the therapist functions as the chief, but unobtrusive, coordinator, who orchestrates many aspects of the adolescent's life, while at the same time maintaining therapist-patient confidentiality so that therapeutic work may proceed. ■

Dr. Kestenbaum is a professor of psychiatry at Columbia University.

On the cusp of adulthood, teens face tasks

Peter Blos has detailed his concept of the developmental tasks of adolescence:

◆ **Loosening of the infantile object ties.**

This can mean leaving home, family or childhood friends for a new environment, namely college or work.

◆ **Integration of residual childhood trauma.**

Early events such as a serious illness or injury or loss of a parent through death or separation may still need to be worked through. Although the adolescent may have understood the event cognitively, emotional understanding of, for example, the finality of death doesn't occur until mid-adolescence.

A 13-year-old's brief period of mourning for a father who died when the patient was 5 might be the first sign of a maturational shift to an abstract mode of thinking.

◆ **Continuity of the adolescent's life and family history.**

One cannot anticipate a future without awareness of one's past. Adolescence is the time when many people question their origins, search for their roots and/or attempt to re-establish relationships with divorced parents.

◆ **Establishment of personal identity.**

Gender identity in terms of sexual role and object choice are solidified in adolescence. An integrated self-concept begins to emerge at this time.

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SEXUAL HEALTH

Teens know more than adults about STDs, but it's not much

American teenagers know more than adults about some aspects of sexually transmitted diseases (STDs), but both groups demonstrate little knowledge about STDs, according to a recent Gallup Organization poll commissioned by the American Social Health Association (ASHA).

Teenagers are more likely than adults to know that STDs are widely prevalent; that some STDs other than HIV/AIDS are incurable; and that some STDs have no symptoms, the study revealed. However, fewer teens than adults were able to name an STD other than HIV/AIDS.

According to the study, 43% of adults and 30% of teens know someone who has had an STD.

The study also demonstrated that schools are increasingly important as primary educators about STDs. Two-thirds of teens first learned about STDs in school, as compared with 36% of adults.

According to the survey, more than half of adults and more than a third of teens said their health care providers spend "no time at all" discussing STDs with them.

"While it is encouraging that young people are somewhat more knowledgeable than adults about STDs, there is still an alarming gap between the level of knowledge and the reality of the epidemic," says ASHA president Peggy Clarke. "The finding that almost one teenager in three knows someone who has had an STD underscores the high risk of STD infection among sexually active teens."

About 1,000 adults and 500 teenagers in the United States were surveyed over the phone last spring.

(turn to 4)

Here's what they said

- 12% of teens and 4% of adults correctly said that STDS other than HIV/AIDS infect one in five people. More adults than teens — 57% vs. 45% — dramatically underestimated STD prevalence, responding that only one in 100 people or less is infected with STDs.
- Significantly more teens than adults (83% and 66%, respectively) answered correctly that some STDs other than HIV/AIDS are incurable. And 83% of teens, compared with 76% of adults, gave the correct response that some STDs have no symptoms.
- Naming an STD other than HIV/AIDS was tougher for teens than adults: 42% of teens and 26% of adults could not answer the question. Among the STDs listed, gonorrhea was named by 51% of adults and 34% of teens, while syphilis was named by 45% of adults and 20% of teens. Relatively few in either group named genital herpes (29% of adults and 23% of teens) or human papillomavirus (5% of adults and 8% of teens), which are the most common STDs. Chlamydia, the fastest spreading STD, was named by only 12% of adults and 3% of teens.
- Asked how much time health care providers spend discussing STDs with them, 54% of adults and 35% of teens said "no time at all." Health care providers spend "very little time" talking about STDs according to 25% of adults and 31% of teens. Another 17% of adults and 34% of teens said doctors spend "some time" or "a lot of time" discussing STDs.
- The younger generation is more likely to have first learned about STDs in school. A full 67% of teens and 36% of adults said they learned about STDs in school. Books, magazines or TV were the initial sources of STD information among adults (28%) more often than among teens (11%). Only 8% of adults and 12% of teens learned about STDs from family members. Only 7% of adults and 3% of teens learned about STDs from health care providers.
- The survey also asked about current sources of STD information. More than half (52%) of teens and 4% of adults get information in school. While only 25% of teens get information from books, magazines or TV, 68% of adults get information from these sources. Only 1% of adults and 11% of teens get information from family members. Only 11% of adults and 5% of teens get information from health care providers.
- Asked what they consider the biggest obstacle faced by people who want to protect themselves against STDs, teens most often cited embarrassment (44%), while adults most often cited ignorance of how to protect themselves from infection (32%).

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"This study reminds us that health educators and the medical community must find more effective ways to communicate about STDs, especially with young people," Clarke says.

Teenagers account for one-fourth of the estimated 12 million new STD infections in the United States each year. In teens, physiological factors, such as an immature immune system, increase the likelihood of getting STDs from unprotected sex. Also, sexually active young people often choose hormonal contraceptives (which offer no STD protection) over condoms, which are highly effective against STDs. ■

For a full report of the study, contact ASHA, PO Box 13827, Research Triangle Park, NC 27709, (919) 361-8400.

Grief counseling

from page 1

ciples to assist the bereaved child. Essentially, the family has the "ghost of presence" even when they are not a part of the counseling interaction.

There can be no doubt that the counselor-child relationship is multilateral, not bilateral. While many counselor-child interactions may take place on a one-to-one basis, the therapeutic system takes place in units of at least three: the child, the family or caregivers, and the counselor.

Family's support of the child

While counselors usually counsel children in their own offices, the helping strategies are typically carried out at home in the family environment. Consequently, counselors who fail to perceive and make use of the helping role of the family are failing to make use of a systems model of caregiving.

The family's involvement and commitment to helping the bereaved child is necessary to achieve healthy reconciliation to the death. Outside the counseling office, the counselor has little influence over the implementation of the proposed helping plan. My experience suggests that the family generally has the greatest influence. Mobilizing the collaborative efforts of the therapeutic triad should result in the greatest potential of helping the child come to reconciliation.

Counselor-child relationship

While we need more formal studies, my experience suggests that the quality of the counselor's relationship with the bereaved child's family may be a critical influence on the relationship that develops between the counselor and child. It only makes sense that counselors who relate well to the child but not to adult family members (if they relate at all) will end up with less collaborative helping assistance from the family.

Without family assistance, working effectively with the bereaved child may be impossible. Generally, one would anticipate that the more complicated the bereavement circumstances (nature of the death, level and nature of attachment of the child to the deceased, etc.), the more important the counselor-family relationship would become.

Counselor's support of the child-family relationship

In exploring important concepts of human development more than 15 years ago, Urie Brofenbrenner suggested that the quality of primary dyadic relationships, such as husband-wife or parent-child, is influenced by the support given those relationships by significant outsiders. For example, marital relationships are strengthened or weakened by the influence of in-laws; the mother-child relationship depends on the support of the father.

As a significant outsider in family relationships, the counselor invariably has an effect — positive or negative. For example, in supporting the family in coping with the death of a member, the counselor may be able to help maintain open, healthy patterns of communication during this naturally stressful period. However, if the counselor over-engages, perhaps even in a co-dependent way, with the bereaved child to the exclusion of the family, then the counselor is unknowingly undermining the overall family.

Family's support of the counselor-child relationship

The family has the potential to either support or undermine the counselor's relationship with the bereaved child. In an instructive effort to protect the interests of their child, the family is constantly assessing the perceived skill level and caring concern of the counselor. A child who resists going to counseling, a helping strategy suggested by the counselor that doesn't seem to help, the counselor's cancellation of a scheduled appointment or general unavailability — these are all circumstances that can cause the family to distrust the counselor.

The model of the therapeutic triad suggests that a vital element in the continuation of a supportive counselor-bereaved child relationship will be the family's support of the counselor's role. ■

Dr. Wolfelt is director of the Center for Loss & Life Transition in Fort Collins, CO, which holds seminars for bereavement counselors. This article was excerpted from a longer chapter on family systems counseling in his new book, Healing the Bereaved Child *(Companion Press). For ordering information, call (970) 226-6050.*

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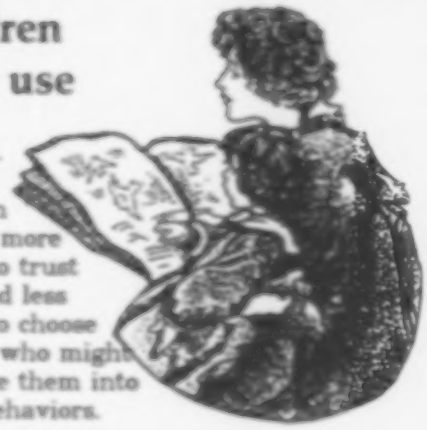
Good relationships with your children can help prevent alcohol and drug use



The best way to keep children away from cigarettes, alcohol, and other dangerous drugs isn't to order them around like a drill sergeant, but to help them feel as comfortable talking to their parents about subjects like sex as about baseball or ballet, according to recent research.

In a two-year study of more than 2,000 fifth and seventh graders, researchers discovered a "very strong" link between positive parent-child relationships and low alcohol and drug use by adolescents.

Role of parenting

Although it has been a long held belief that peer pressure induces children to start smoking and drinking, it's apparently not as important as an adolescent's relationship with his or her parents, says Dr. Deborah Cohen, who reported her findings in the journal *Pediatrics*.

Dr. Cohen, who is a researcher at Louisiana State University, found that children whose parents "spent more time with them and communicated with them more frequently" had lower rates of experimenting with alcohol and tobacco.

"What's more," says Dr. Cohen, "children whose parents listen to them with empathy are less likely to exhibit disruptive behavior or choose friends who might be considered 'bad influences.'" Dr. Cohen offered the following suggestions for parents to develop strong, loving, mutually respectful relationships with their children, and thereby help prevent alcohol or drug experimentation:

- Do give children chores, but not as punishment. Chores as punishment are detrimental to a good relationship.
- Don't try to screen your children's friends. Instead of trying to get them to stop associating with certain other children, foster your relationship instead. Your children will be more likely to trust you, and less likely to choose friends who might pressure them into risky behaviors.
- Do try to keep an open mind. You can't force your children to like the Beatles or the Rolling Stones, but you can discuss what you like about your favorite bands. Likewise, you may not like the music that your children embrace, but making blanket criticisms of their likes and interests can result in mistrust. Instead, encourage your children to tell you what they like about various music, film, and video personalities.
- Do express your expectations simply and clearly. Rules, if stated and explained clearly, can serve as the foundation to a good relationship. Remember that you don't have to let your children attend unsupervised parties. But it helps to explain your reasoning. Children often can appreciate that their parents don't want bad things to happen to them.

Dr. Timothy Rivinus agrees that a good parent-child relationship is the key to preventing high-risk behaviors by your child. He offers the following additional suggestions:

- Set the family standards on drug and alcohol use early. Tell your children what the rules are, clearly and firmly.
- Familiarize yourself with signs and symptoms of high-risk behaviors. Be a good role model.

Continued . . .

. . . *Continued from previous page*

- Establish consequences for violating family rules. When you make a rule, explain the reasoning behind it, and make the consequences for breaking the rule clear in advance. Impose the consequences without exception every time a child breaks a rule. Examples of effective punishments include loss of privileges, such as driving the car or spending unsupervised time with friends.
- Set aside time every day to talk to your children about what is happening in their lives, how they feel, and about what they think. Let them talk; you don't have to have answers. Listen carefully, and summarize what they've said to show that you've heard them. When appropriate, offer your own personal experiences.
- Respect your children's experiences and feelings.
- Help your children to establish personal goals. Take time to define goals — academic, athletic, social, personal. Goals should be achievable, and should be both the short-term (next month) and long-term (in the next year or two).
- Be sure to celebrate, without insisting on, success. Teach your children how to accept and learn from their inevitable failures, and handle success gracefully.
- Take time to get to know the parents of your children's friends. They can enrich your life, help you understand your children's age group and social concerns, and help you to be a better parent.

Source: Part of this handout was adapted with permission from articles by Bill Hendrick appearing in *The Atlanta Journal/The Atlanta Constitution*.

Dr. Rivinus is Chief of Mental Health Services for the Harvard Community Health Plan of New England.

The Brown University Child and Adolescent Behavior Letter

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Prepared by Mary-Kim Arnold, editorial assistant.

News Updates

- More minority and female college candidates than other students **opted out of submitting standardized test scores** with their applications to Lafayette and Dickinson Colleges, which dropped their test score requirements last year. The two colleges join others that have decided that the SAT and ACT don't provide accurate information about student potential. Test-optional policies at Bates and Bowdoin Colleges have resulted in increased applications, admissions and enrollments from minorities and women in particular.
- British doctors reported in the journal *Cell* that they've found the **gene responsible for Batten disease**, a degeneration of the brain that causes children to become demented and die. Dr. Sara Mole and colleagues at University College London, working with laboratories in the Netherlands, the United States and Australia, tracked the recessive gene in 150 families. Batten disease affects about one in 20,000 children.
- Although chronic headaches may be a sign of serious structural lesions, **brain imaging should usually be reserved** for children with clinical evidence of an underlying lesion, a group of pediatricians says. Writing in the September issue of *Pediatrics*, they listed indications for brain imaging: atypical headache pattern, neurologic abnormalities, systemic symptoms and parents' or doctors' concerns about brain tumors.
- Leadership in health-care program development and research **designed to improve health services for Californians** are the goals of the newly organized California Health Collaborative, a group of non-profit foundations based in Fresno. With board members from community hospitals, public health agencies, health maintenance organizations and insurers, the organization is intended to serve as a forum to stimulate and facilitate shared projects and research among hospitals and other health service providers.
- Indonesia is in the middle of a **campaign to immunize about 21.7 million children** against polio as part of a global effort to wipe out the crippling disease. According to Reuters, the $19 million Indonesian program, funded by U.S. and Australia donors, aims to meet the goals of the 1990 World Summit for Children to eradicate polio and neonatal tetanus and to curb measles by the year 2000.
- The American Academy of Pediatrics this month issued a policy statement saying that **women should stay in the hospital at least 48 hours after giving birth**. The average length of stay for hospital deliveries dropped from 4.1 days in 1970 to 2.6 days in 1992, the Centers for Disease Control and Prevention (CDC) reported recently. The CDC blames the shorter stays on managed care and increased hospital costs.
- States reported spending $2.6 billion in fiscal year 1994 to **house, monitor and treat juvenile offenders**, according to a report issued by the National Association of State Budget Offices (NASBO). Residential placements accounted for 65%, or $1.7 billion, of state juvenile justice expenditures, according to the report. Coming in next were community placements (23%), followed by delinquency prevention programs (8%) and post-residential care (3%).

Resources

For disabled children

The "Children's Disability Bookshop Catalog" lists children's books that cover a variety of health topics, including autism, Tourette syndrome, learning disabilities and mental illness. **Cost:** $3, $5 for audiotape. **Call:** Twin Peaks Press, (360) 694-2462.

Reaching urban youth

A video called *Street Peace* features teens from violent urban neighborhoods who tell their stories. The 60-minute video is accompanied by a 45-page curriculum. **Cost:** $189.95, order #2607. Another video, *Gangs*, explains the signs and symptoms of gang membership. **Cost:** $69.95, order #2609. **Call:** Bureau for At-Risk Youth, 1-800-99-YOUTH.

Booklets talk to teens

A series of booklets uses a narrative approach to talk to teenagers about HIV and AIDS, anger, self-esteem, smoking, alcohol and drug refusal skills, driving under the influence, respect and sexual abstinence. All eight titles in the RealStory Booklet series are also available in Spanish. **Cost:** $1.25 each, bulk discounts available. **Call:** Channing L. Bete Co., 1-800-628-7733.

Coming Up

The **National Symposium on Child Victimization**, hosted by the Children's National Medical Center, will address responses to child maltreatment, Nov. 9-12 in Washington, DC. **Call:** (202) 884-4993.

Advocates for Youth will focus its 15th-anniversary conference on teen sexuality, Dec. 8-10 in Washington, DC. **Call:** (202) 347-5700.

The **Family Research Consortium** will sponsor a summer institute for family researchers, June 20-23, 1996, in San Diego, CA. **Deadline:** March 15. **Call:** (919) 966-3318.

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WHAT'S NEW IN RESEARCH

Hurricane's impact on kids is far-reaching and hard

Hurricane Andrew, which devastated Dade County, FL, in 1992, didn't only affect the children and adolescents directly exposed to the disaster, according to two separate studies of posttraumatic symptomatology. Children in a comparison group north of Miami, as well as adolescents who experienced common stressful events after the hurricane, also suffered from posttraumatic symptoms. While children in the immediate pathway of the storm had more severe symptoms, children at a Miami Beach elementary school in one study had the same prevalence of mild and moderate categories of posttraumatic symptomatology. In a study of adolescents, stressful events, such as moving or changing schools, as a result of the disaster, proved to be more strongly associated with symptoms of posttraumatic stress disorder than did magnitude of contact with the actual disaster. Post-disaster planning should not overlook children and adolescents exposed to the fallout of the disaster, the researchers advise.

"Psychological effects of Hurricane Andrew on an elementary school population," Jon A. Shaw, MD, et al., and "Posttraumatic stress disorder in adolescents after Hurricane Andrew," Carol Z. Garrison, PhD, et al., *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(9):1185-1201, 1995. For reprints, write to Dr. Shaw, Department of Psychiatry D-29, PO Box 016960, Miami, FL 33101; and Dr. Garrison, Department of Epidemiology and Biostatistics School of Public Health, University of South Carolina, Columbia, SC 29208.

Use of force in sex abuse related to victim's outcome

The use of force predicted a higher level of trauma symptoms for sexually abused girls — but only for those who were abused by someone outside the role of father, according to a study of 134 young victims. Their average score on the Children's Depression Inventory (CDI) placed them in the top 10th percentile for depression, compared to a 64th percentile ranking for those abused by a non-father figure without force. Surprisingly, force was *not* related to a more serious outcome when the abuser was the victim's father, stepfather or mother's boyfriend. Among these girls, in fact, those abused with force had lower levels of depression and nearly identical scores on self-worth as those abused without force. The researchers hypothesize that betrayal of trust by a father figure may be more centrally related to trauma, with force not necessarily adding to symptoms. By contrast, violence may add to the trauma of being abused by someone with whom the victim was less close.

"The relationship of abuse characteristics to symptoms in sexually abused girls," Ferol E. Mennen, DSW, and Diane Meadow, PhD, *Journal of Interpersonal Violence*, 10(3):259-274, 1995. For reprints, write to Dr. Mennen at the University of Southern California School of Social Work, MRF 214, University Park, Mail Code 041, Los Angeles, CA 90089.

Separation anxiety may be related to panic disorder

Childhood separation anxiety disorder lessened the age at onset of panic disorder in a study of outpatients at an anxiety treatment facility. Although the two disorders are diagnostically distinct, separation anxiety and panic disorder may be linked by the same underlying neurophysiological vulnerability, the researchers theorize. A total of 231 patients with panic disorder were compared with 131 surgical outpatients on demographic variables and familial risk of psychiatric disorders. The patients with panic disorder had a significantly higher rate of childhood separation anxiety disorder and higher familial risks of panic disorder with and without agoraphobia, as well as alcoholism.

"Age at onset of panic disorder: influence of familial liability to the disease and of childhood separation anxiety disorder," Marco Battaglia, MD, et al., *American Journal of Psychiatry*, 152(9):1362-1364, 1995. For reprints, write to Dr. Battaglia, Instituto Scientifico H. San Raffaele, Department of Neuropsychiatric Sciences, University of Milan School of Medicine, 29 via Prinetti, 20127 Milan, Italy.

Excess weight in pregnancy leads to obesity for teens

Excessive weight gain during the latter half of pregnancy in young teenage women contributes to postpartum obesity, according to a new study. Adolescent weight gain and obesity increase the long-term risk of chronic diseases such as diabetes and heart disease. A study of 274 young, low-income, mostly African-American and Hispanic women between the ages of 12 and 29, found that those who gained more than one and a half pounds a week from the 20th week through the 36th week of pregnancy weighed an average of 12% more six months after birth than they weighed before pregnancy. (All were in the normal weight range before pregnancy.) Women with low or moderate weight gain weighed an average of only 5% to 7% more six months after birth. The study found that this excessive rate did not greatly enhance fetal growth or gestation duration. The study indicates that most of the women with excessive rates of weight gain were young teenagers. Weight during pregnancy by the still-growing teenager may be easier to gain and more difficult to lose than it is for older women, according to the study.

"Gestational weight gain, pregnancy outcome and postpartum weight retention," Theresa O. Scholl, PhD, MPH, et al., *Obstetrics and Gynecology*, 86(3):423-427, 1995. For reprints, write to Dr. Scholl at the Department of Obstetrics and Gynecology, University of Medicine and Dentistry of New Jersey, 401 Haddon Ave., Camden, NJ 08103.

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Keep Your Eye On

... blood lead levels.

Despite substantial progress in reducing children's exposure to lead-based paint, as recently as 1991, 9% of American children had blood lead levels of 10 µg/dL or higher — levels that can adversely affect intelligence and behavior, according to the Centers for Disease Control and Prevention (CDC). That was the year the CDC recommended screening all children for lead exposure. But lead poisoning is unevenly distributed among different communities and population subgroups. For example, the prevalences of elevated blood lead levels have ranged from 37% among black children in central cities to 5% among non-Hispanic white children who do not live in central cities.

... language & birth weight.

The Missouri Department of Health is planning a population-based study to measure speech, language and hearing disorders in children who were underweight at birth. Funded by the National Institute on Deafness and Other Communication Disorders, the study will measure hearing sensitivity and middle-ear function; assess central auditory processing, speech and language development and non-verbal cognitive performance; and evaluate risk factors for developmental delay in children with hearing or balance impairments, speech and language disorders and cerebral palsy. The data will be correlated with health and medical history from an earlier study that tracked a group of very low, moderately low and normal birth weight infants from the neonatal period.

... fears for the future.

American kids are scared. Fears of poverty, AIDS and physical and sexual abuse color children's perceptions about their lives and futures, according to a survey by KidsPeace, a Pennsylvania-based organization focused on children in crisis. As a group, 10- to 13-year-olds told surveyors that they are more likely to die soon or be abused than that they will start smoking or drinking. Nearly half (47%) of the children questioned foresee bleak expectations in life, saying they expect to be unhappy in the future. And the survey results suggest that most parents are ill-equipped to deal with today's problems. The good news? A full 93% of the children believe their parents love them. In releasing the survey, KidsPeace launched a program to train parents to help their children deal with their fears and problems.

KidsPeace, 575 Madison Ave., Suite 1006, New York, NY 10022, (212) 605-0153.

... spoiled appetites.

Sugary beverages may be the culprit behind some common childhood problems. Children who drink large amounts of beverages that contain a lot of sugar but little nutrients may have poor appetites at the next meal and poor weight gain. British researchers have coined the term "squash-drinking syndrome" — in England, squash drinks are fruit-flavored beverages popular among young children — to describe the problems that can result when children have too many of these soft drinks, especially before meals. Reporting in the *Archives of Disease in Childhood*, doctors studied eight toddlers who had vague problems involving poor appetite and weight gain, loose stools and misbehavior at mealtime. A review of the children's diets showed that they drank large quantities of squash drinks, often before meals. When parents decreased the amount of these drinks they gave their children, all gained weight, and their other symptoms improved as well.

Recommended Reading

The Custody Evaluation Handbook: Research-Based Solutions and Applications
Barry Bricklin, PhD
Brunner/Mazel, New York, 1995
300 pages, $45.95 (hard)
To order, call 1-800-825-3089

Written by an expert in custody evaluation, the book offers alternatives to what the author calls the "negative incident model," in which each parent compiles a long list of grievances against the "opponent." He advocates, instead, a test-based approach that measures how successful each parent actually is at the job of parenting. Advocating an evaluation that determines the impact of a parent's behavior on a child, rather than the behavior itself, the book emphasizes the importance of obtaining measurements from both child and parent. It also includes a chapter on getting accurate information from kids whose loyalty is split between their mother and their father.

Disclosure Processes in Children and Adolescents
Ken J. Rotenberg, Editor
Cambridge University Press,
New York, 1995
237 pages, $44.95 (hard)
To order, call 1-800-872-7423

This research monograph pertains to disclosure of, not only daily thoughts and emotions, but modern and controversial societal problems such as divorce, AIDS and sexual abuse. Little attention has been given to these processes in both children and adults. The chapters examine how, to whom and under what conditions children and adolescents disclose their personal thoughts and emotions. Chapters cover new research and relate to contemporary issues of the role of disclosure in family therapy and sex abuse. As the frontispiece quotes, "To be known, and to know others, is critical to all social relationships."

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COMMENTARY

Spending quality time

By Gary D. Sandefur, PhD

Given the difficulties already experienced by single-parent families, we should be concerned about efforts to reform welfare programs that constrain the ability of single mothers to spend time with their children without significantly increasing their income.

Common sense suggests that single parents will have less time to spend with their children than two parents who can share responsibility and cooperate with each other. Further, single-parent families have less stable membership: Grandmothers, mothers' boyfriends and stepfathers are more likely to move in and out. This creates uncertainty about household rules and parental responsibility.

Single mothers spend significantly less time with their children and provide less supervision than two parents. Results from the National Survey of Families and Households, for example, show that mothers in two-parent families report that they have dinner with their child an average of one more time during each two-week period than mothers in other types of families. Although this difference may seem small, the difference over months and years is sizable.

Single mothers and married mothers do not differ on all indicators of the quantity and quality of parenting, but they do on many. In analyses with data from the High School and Beyond Survey, we found that differences in parental involvement, supervision and aspirations accounted for half the difference in the rate of dropping out of high school, 20% of the difference in the risk of teen births and all the differences in the risk of idleness.

Most of us agree that in the long run, employment offers single mothers a better future than a life on welfare. Employment increases a mother's earning power, as well as her self-esteem. Having a mother who is attached to the labor force will also help the children when they are looking for jobs.

But the cost of full-time work for single mothers is that they have less time to spend with their children. The loss of parental time could mean less parental involvement and supervision, which is harmful to children unless the children are placed in good day care and after-school programs. The end result of current welfare reform will depend a great deal on how it affects the number of hours the mother works, the net income of the family after deducting child care and other expenses, and the quality of substitute care. If a child has less time with the mother, and the family has no more income, the child is likely to be worse off under the new system. If the child has less time with the mother, but good child care and more income, that child is likely to be better off. ■

Dr. Sandefur is a professor of sociology at the University of Wisconsin at Madison and the co-author, with Sara McLanahan, PhD, of Princeton University, of Growing Up with a Single Parent: What Hurts, What Helps *(Harvard, 1994). Dr. McLanahan will discuss their findings and recommendations next month at the American Association for Marriage and Family Therapy conference.*

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Vol. 11, No. 11 November 1995

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PS 025074

Sleeping climate may explain SIDS

By J.A. Corbyn, MSc, DIC

Postmortem investigations of sudden infant death syndrome (SIDS) cases reveal similar autopsy findings and environmental circumstances. The deaths are typically associated with cool, damp climates, winter time, pollution and tobacco smoking. The young victims were also sleeping in a face-down position.

Etiology

But an exact explanation for these deaths continues to elude researchers. Until recently, they have emphasized illness, health or genetic problems, rather than the interactions between the child and the sleeping environment.

SIDS can be explained in terms of the micro-climate of the sleeping environment, with the risk determined by the possibility of rebreathing previously exhaled air.

Exhaled air is normally less dense than the surrounding atmosphere so that it moves up and away from the face. If the exhaled air becomes cooled or trapped in the facial region, however, it may be inhaled. This baby is sleeping in a dangerous environment.

Gaseous exchange between the facial region and the surrounding atmosphere depends on a number of processes:

- **Cooled exhaled air.** Exhaled air may cool sufficiently in the bed to form a stable zone containing

(turn to 2)

Inner cities sustain desensitization

By David A. Levine, PhD

In his famous longitudinal study of members of the Harvard College class of 1937, *Adaptation to Life*, George E. Vaillant, MD, begins with the proposition that mental health is measured in how well someone adapts to the setbacks that are bound to occur.

Violence

Experientially, the subjects of Vaillant's inquiry are light years away from the inner-city youth who are the focus of a Yale University study. But the perspective is much like Vaillant's: That "setbacks" have a profound effect on human psychology, and that there are limits to what people — especially young people — can endure without significantly altering how they view themselves in relation to the broader society.

Specifically, Mary E. Schwab-Stone, MD, and her colleagues believe that when young people are constantly exposed to the threats and actuality of physical violence, and do not feel safe in their environment, they adapt in a way that squelches hope, increases restlessness, and makes aggressive behavior more likely.

"To the extent that this pattern of adaptation becomes normalized and is viewed as expected and reasonable rather than pathological," they write,

(turn to 4)

This month's client handout: When a teen quits drugs

SIDS

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excess carbon dioxide. The cooling processes depend on bedding temperature, bedding moisture, room temperature, minute particles of smoke, and impingement of exhaled air on bedding.

- **Turbulent mixing at the face**. Drafts at the face decrease the SIDS risk. Air velocities approximating 0.1 meters per second are typically required to dissipate cooled exhaled air.
- **Impeded exhalation**. The jet of air emerging from the nose can disperse exhaled air if not impeded.
- **Plug flow in the bedding**. If the bedding material is both permeable and porous, such as a bean bag, the exhaled air moves into the bedding during expiration and from the bedding to the lungs during inspiration.
- **Oscillatory flow between the lungs and bed**. Re-breathing exhaled air can occur when the exhaled air from the nose moves to the bed. This flow is driven by the contraction of the chest and jet action of the nose during exhalation. On inhalation, the process reverses, and the air from the bed is returned to the lung. This oscillatory flow is avoided by putting the baby to sleep on his or her back, making sure that exhaled air not be impeded by bedding.

The relative significance of these processes depends on the circumstances. The oxygen movement from the general body of air to the facial region is usually sufficient for health, whereas the carbon dioxide movement may not be. Molecular diffusion is too slow to safely remove excess carbon dioxide in the bed.

If a baby who has spent many hours in a high carbon dioxide atmosphere is exposed to fresh air, the minute volume would be expected to fall. The baby would now be expected to suffer from hypoxia.

In sleeping arrangements associated with SIDS, inspired carbon dioxide levels in the range of 0.5 to 4 percent have been measured, with a corresponding reduction in oxygen levels. The industrial limit for carbon dioxide in inspired air is 0.5 percent at standard pressure for eight hours exposure.

In humans, total body stores of carbon dioxide are about 80 times bigger than the corresponding oxygen stores. In the absence of any ventilation at the face, oxygen stores are used up before the excess carbon dioxide in the body has produced dangerous health effects. The result is hypoxia, a decrease in normal levels of oxygen in inspired gases that can cause death by asphyxia.

If the face is partially ventilated, inspired air can contain enough oxygen to sustain life, but also contain an excessive carbon dioxide content.

The principal control of normal breathing is the partial pressure of carbon dioxide in the blood, as was originally established a century ago.

The initial effect of elevated carbon dioxide levels in inhaled air is an increase in minute ventilation, the total inflow of air per minute. Inhaling a gas with 2 percent carbon dioxide doubles minute ventilation.

Reduction of the oxygen content of inspired air can also increase the minute ventilation. A reduction of oxygen content from 21 percent to 12 percent doubles the rate of ventilation.

In some circumstances, the hypoxic response in babies may be ineffective in generating corrective behaviors. Extended breathing of a hypercarbic atmosphere results in an elevated partial pressure of carbon dioxide in the blood. After extended exposure, breathing is controlled by the carbon dioxide level of the blood, but this is at a higher level than normal.

Historical considerations in SIDS

Sudden infant death syndrome (SIDS), also known as "crib death" or "cot death," has been silently stalking infants for centuries.

The statistics of the phenomenon of "overlaying" were presented in the Jan. 27, 1855, issue of the *Lancet*, which included the observation that overlaying was rarely due to the mother physically lying on top of the baby. When babies were still dying, despite the use of separate beds for babies in the 20th century, what was known as overlaying was replaced by crib or cot death, which almost invariably occurs in children sleeping in a separate bed.

Sixteenth-century parents used an arcuccio, a framework placed over the sleeping baby to improve ventilation at the face. In 1895, the *Lancet* suggested that mothers make sure that babies in bed with them have adequate ventilation at the face.

The rate of SIDS in Western societies was typically 1 per 500 babies before the recent introduction of the practice of putting babies to sleep on their backs. Rates as high as 1 per 100 among particular social and ethnic groups have been recorded.

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When substance abusing teens achieve abstinence, it rocks the family boat

If your teen is battling with an alcohol or drug addiction, it is easy to focus exclusively on his or her achieving abstinence. But according to Howard Liddle, Ed.D., when teens stop using drugs or alcohol, the work of recovery has just begun. As director of the Center for Research on Adolescent Drug Abuse at Temple University, Liddle says that it is important to consider "the many aspects of the kid's life that actually keep drug use going." Among these aspects, the teen's family plays a critical role in the recovery process.

Research has suggested that substance abuse by one member of a family system changes the way the family adapts and functions. "It prompts extreme behavior," says Liddle. "One result is that parents tend to narrow their conception of who their child is," he says.

Dynamics change

Liddle says that parents may stop believing in their own abilities to help their child. This response could be devastating, since this is a time when the teen is most vulnerable, and most in need of the support of family and friends.

It is easy to consider abstinence as enough, and at this point, many parents are apt to feel that their child has stopped using, so what's the big deal? "The big deal," says Philip P. Muisener, MSW, a clinical social worker at Youth and Family Services in Connecticut, "is that there's this magnetic pull to going back to the way things were."

Things don't get better right away, says Muisener, the family has to learn a whole new way of interacting, which most likely will stir up an array of feelings that may have been suppressed for years. This could amount to a family crisis, which ironically, could put the teen at risk for relapse. Muisener says that this time of shifting family dynam-

Continued . . .

Stages of treatment for substance abusing teens

Teens recovering from a substance dependency go through four stages, according to Howard Liddle, EdD. Understanding these stages can help parents to examine their own roles in the family systems, thus aiding the progress of treatment.

- **Stage 1: Disengagement** — Treatment helps parents to develop new ways to approach the teen. Often, parents see how they unintentionally may have enabled the teen's behavior. Treatment gives them ways to change.
- **Stage 2: Empowerment** — Parents join support groups, learn how to set limits and consequences that provide structure. Treatment also provides tools for more effective communication.
- **Stage 3: Integration** — Families address unresolved dynamics and put them in the context of overall family life. At this stage, families run the risk of regressing to old patterns, which can include the teen's substance use. For this reason, it is critical that families use their support networks, and not lose hope.
- **Stage 4: Individuation** — Teens work on the normal developmental task of adolescence, which includes developing their own identity and separating from their parents. Peer relationships can be extremely important in this stage. Young people's Alcoholics and Narcotics Anonymous groups, as well as other nonabusing friends, can show teens that they're not alone and help them find a place in their posttreatment world.

. . . *Continued from previous page*

ics can be extremely stressful for everyone. "It can be mind boggling, Twilight Zone weird to be talking about feelings in a family that hasn't talked about feelings before," or taking on roles that are unfamiliar or uncomfortable. It is in these middle stages where the adolescent is most at risk for relapse, says Muisener.

Many factors involved

Outside of the immediate family, Liddle says that "the school, the juvenile justice system, and the teenager's peer group are the primary foci of assessment and intervention."

Peers are particularly important in this transition to a drug-free life, says Muisener, who occasionally invites a teen's friends — provided they're drug-free — to treatment sessions. Liddle suggests that the therapist, school officials, including teachers and administrators, and counselors all should be cultivated as friends of the family, all of whom are working together in the best interest of the teen.

For more information, contact any of the following resources:

- American Council for Drug Education
  204 Monroe Street
  Rockville, MD 20850
  (301) 294-0600
- National Clearinghouse for Alcohol and Drug Information
  P.O. Box 2345
  Rockville, MD 20852
  (301) 468-2600
- National Federation of Parents for Drug-Free Youth
  8730 Georgia Avenue, Suite 200
  Silver Spring, MD 20910
  (800) 554-KIDS
- National Self-Help Clearinghouse
  33 West 42nd Street
  New York, NY 10036

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Prepared by Mary-Kim Arnold, editorial assistant.

If a baby who has spent many hours in a high carbon dioxide atmosphere is exposed to fresh air, the minute volume would be expected to fall as a lower ventilation rate is now required to maintain the blood's carbon dioxide level at the acclimatized level. The baby would now be expected to suffer from hypoxia.

The prediction of hypoxia in an individual who is suddenly exposed to fresh air after spending an extended period in a high carbon dioxide atmosphere is analogous to the hypoxia that can result from hyperventilation followed by breath holding.

This might help explain hypoxia in SIDS victims. This is not a far-fetched lethal scenario: A baby sleeps face down all night — in an atmosphere of excess carbon dioxide — and, in the early morning, is suddenly exposed to fresh air as a result of waking up. ■

Dr. Corbyn is the author of two books on SIDS, Environmental Causes of Sudden Infant Death *(1992) and, more recently,* Causes and Prevention of Sudden Infant Death *(1994). Both are published by Western Technical Press, PO Box 195, Fremantle, Western Australia. For more information, write to Dr. Corbyn at the Department of Biological and Environmental Science, Murdoch University, Murdoch, Perth, Western Australia 6150.*

At the Library

For the last of our three-part series on books about bullies, we go back to the middle age group — grades two to four.

Although bullies come in all sizes, ages and shapes, they are most prevalent in the lower elementary grades. In the following books, most of which are available at local libraries, the bully has troubles of his own, such as not being accepted, having been held back and being a poor reader.

King of the Playground by Phyllis Reynolds Naylor, Atheneum, 1991. Sammy has taken over the playground. When he announces, "I'm king of the swings," Kevin stays off the swing set. The next day, Sammy says, "I'm king of the monkey bars," and Kevin doesn't climb. But when, the day after that, Sammy proclaims himself "king of the sandbox," Kevin puts one foot in, then the other.

The following books are broken into chapters, an important milestone for the newer reader.

First Grade King by Karen Lynn Williams, Clarion, 1992. Looking forward to learning to read and having real homework like his third-grade brother, Joey King is really excited and ready for first grade. But he wasn't ready for Ronald, who made fun of Joey's last name, calling him "King Kong." Joey is an average kid making his way through the first weeks of first grade.

Corey Coleman Grade 2 by Larry Brimner, Henry Holt, Redfeather Book, 1990. Corey's mother makes him invite the whole class to his 7th birthday party, including Delphinius Lane, the class bully. Delphinius spoils the party, just as Corey predicted, but Corey learns an important truth about himself when he tries to even the score. Corey comes from a single-parent background.

How to Be Cool in the Third Grade by Betsy Duffey, Viking, 1993. It's a new school year for Robbie York, and this year he wants to be cool. He wants to wear plain white underwear, jeans to school and walk to the bus stop alone. All these he accomplishes, but then he's chosen to be book buddy for Bo Haney, who tells the whole class that Robbie's underwear has superheroes on it.

Luke's Bully by Elizabeth Winthrop. Viking, 1990. "You'd better bring me a cupcake tomorrow or you're in big trouble," demands Arthur, the fattest, meanest kid in third grade. Shy, skinny Luke tries bribing him with a part in the school play, but the deal falls through. When Arthur follows Luke home, Luke's mom befriends Arthur and invites him over to play with Luke every Tuesday after school. Things change when Luke discovers that Arthur has reading difficulties and needs glasses.

Compiled by Barbara Goldberg, MLS

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Unsafe environments

from page 1

"the climate of violence will only be sustained."

The study is based on a comprehensive survey of high-risk behaviors, attitudes and indicators of adaptive behaviors that was administered to 2,248 students in the sixth, eighth and 10th grades in the New Haven, CT, public school system. The study sample was more than one-half female (55 percent) and primarily of minority ethnicity: African-Americans (61.3 percent), Hispanics (22.4 percent) and whites (16.2 percent).

Slightly more than half lived in a two-parent household; the remainder with one parent or other adults. Nearly half received free lunches, indicating a relatively high level of economic advantage.

The survey was administered in Spanish to students who spoke only that language or preferred to take the translated version (3.8 percent).

The survey queried students about their exposure to violence ("During the past year, how many times have you seen someone shot or stabbed?"), and assessed feelings of safety in four domains: home, neighborhood, school and on the way to school.

Students were asked attitudinal questions about their:

- Willingness to use physical aggression in response to various conflict situations, such as being insulted, having a family member insulted, having something stolen, being hit.
- Willingness to risk harm from various activities, such as substance use, gun carrying, fighting, dropping out of school and sexual intercourse without a condom.
- Expectations of the future, including graduating from high school, going to college, having a job that pays well, having a happy family life and staying in good health most of the time.

Finally, the study focused on adaptation, asking questions designed to assess depressed mood and anxiety in the past year; aggression and antisocial activities such as fighting, arrest, vandalism, carrying a gun; alcohol use in the past 30 days; and school achievement.

The study found that young people who are exposed to violence are more likely to be physically aggressive, engage in risky behaviors and have low expectations for the future. Such children are also at higher risk for mood problems, aggressive or antisocial behavior, alcohol consumption and poor academic work, and are more likely to have committed violent acts themselves.

Perhaps the most significant finding, Schwab-Stone says, is the apparent relationship between violence exposure and underestimation of risk, which she sees as "a kind of desensitization" reflecting "a pathological adaptation to chronic threat that characterizes the development of kids in our inner cities." It is something she has confirmed in her own clinical practice with young people in the community.

"Even with children who are not presenting with posttraumatic stress disorder, there is a noticeable effect of violence exposure on the child's psychology," says Schwab-Stone, Harris Associate Professor of Child Psychiatry at Yale Child Study Center.

The major limitation of the study is that the results demonstrate only an "association" between violence exposure and feeling unsafe on one hand and the predicted psychological and behavioral features on the other.

"One cannot say that violence exposure or feeling unsafe causes any of the attitudes or aspects of adaptation that are significantly related, statistically speaking, to them," the researchers write. "Rather, one can say that the pattern of association is highly suggestive."

Future research, Schwab-Stone says, will be directed to demonstrating consistent relationships between violence exposure and the attitudes and behaviors reported by a large proportion of youths in the community. ■

David Levine is a freelance writer from Massachusetts.

Mary E. Schwab-Stone, et al., "No Safe Haven: A Study of Violence Exposure in an Urban Community," Journal of the American Academy of Child and Adolescent Psychiatry, 34:1343-52, 1995. Contact Dr. Schwab-Stone at Yale Child Study Center, (203) 785-2545.

Here's what they said

- More than 40 percent of the students surveyed reported exposure to a shooting or stabbing in the past year, and 74 percent reported feeling unsafe in home, neighborhood, school or on the way to school.
- Exposure to violence and feelings of being unsafe were more pronounced in low-income families (students receiving full free lunch).
- White children were less likely than other racial and ethnic groups to have unsafe feelings from exposure to violence.
- Eighth-grade students had greater violence exposure than sixth- or 10th-grade students, although it is likely that many 10th-graders who would have reported violence exposure had dropped out of school between eighth and 10th grades.
- Although boys were more exposed to violence than girls, there was no difference in their feelings of being unsafe. Boys were more likely to exhibit aggressive behavior, and girls were more likely to report feeling depressed or anxious.

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Birth weight related to mom's weight gain timing

Inadequate maternal weight gain in the second trimester may have a greater impact on overall infant birth weight than weight gained during either the first or second trimesters, according to a California study. In what may be the first large-sample study to measure this relationship, researchers found that *when* a pregnant women gains weight may be significant. A review of the records of 2,994 low-risk, non-obese white women who delivered between 1980 and 1990 at Moffit Hospital of the University of California, San Francisco, found the strongest association between maternal weight gain and birth weight during the second trimester. Only gestational age was a more important predictor of birth weight. Each kilogram of maternal weight gain in the second trimester was associated with a 32.8 gram increase in birth weight, compared with an 18 g/kg increase for the first trimester and a 17 g/kg increase for the third. Because the fetus grows most rapidly during the third trimester, researchers had expected to find the strongest association between maternal weight gain and birth weight during the last trimester. However, no important change in birth weight was seen for the group whose weight gains were low only in the third — or first — trimester. In contrast, patterns of low weight gain during the first and second trimester, or during the second and third trimester, were associated with significant decreases in birth weights of 133 and 88.5 g, respectively.

Barbara Abrams, DrPh, RD, and Steve Selvin, PhD, *Obstetrics and Gynecology*, 86(2): 163-169, 1995. For reprints, contact Dr. Abrams at the School of Public Health, 426 Warren Hall, University of California-Berkeley, Berkeley, CA 94720.

Group therapy may help teens with social phobia

Adolescents with social phobia may benefit from structured group therapy, if the findings of a small, preliminary study are confirmed. Five adolescents were treated in a 16-session group treatment program, with parental involvement in selected sessions. Treatment involved skills training (social skills, problem solving and assertiveness), cognitive restructuring, behavioral exposure and homework. The teens' self-reports of anxiety and depression, taken throughout treatment, showed significant improvements over a one-year follow-up period. Behavior test measures also indicated a decrease in subjective anxiety ratings after treatment, which was maintained at follow-up. One year after treatment, four of the adolescents had a complete remission of social phobia, and the fifth was in partial remission.

"Cognitive-behavioral group treatment for social phobia in adolescents: a preliminary study," Anne Marie Albano, PhD, et al., *Journal of Nervous and Mental Disease*, 183:649-656, 1995. For reprints, write to Dr. Albano at the Department of Psychology, University of Louisville, Louisville, KY 40292.

Foster care children have more psychological trouble

Available evidence suggests that the prevalence of psychopathology among children in foster care is higher than would be expected from normative data, even when this population is compared to a group of economically disadvantaged children who had never been placed in out-of-home care. The researcher reviewed the literature from 1974 to 1994 and says that, even though the foster care system is overburdened, it could provide additional services to a relatively small number of children identified as being at the highest risk of psychopathology.

"Psychopathology among children placed in family foster care," Daniel Pilowsky, MD, *Psychiatric Services*, 46(9):906-910, 1995. For reprints, write to Dr. Pilowsky, Kennedy Krieger Institute Family Center, 2901 E. Biddle St., Baltimore, MD 21213.

'Getting tough' won't deter most juvenile criminals

Except for a small number of juvenile offenders, the prospect of transfer to adult court did not appear to provide a deterrent to crime, according to a recent study. Although trying young offenders as adults has been seen as one way to "get tough" on juvenile crime, the study refutes the proposition that juveniles transferred to adult court would receive greater punishment than they could expect in juvenile court. Researchers examined 111 juvenile cases transferred to adult court, and compared them with a random sample of delinquents adjudicated in juvenile court for conduct that would constitute felonies if committed by an adult. Cases transferred to adult court were far more likely to be pending and unresolved, as compared to the sample from the juvenile justice system. For most cases, transfer to adult court didn't mean that the court was tougher. Of the young men sent to adult court, 6.3 percent were sent to prison, and another 17 percent were put on probation. By contrast, nearly one-half of the sample that went through juvenile court were put on probation, and 20.7 percent were placed with the Division of Youth Services and sent to an institution.

"A comparison of the dispositions of juvenile offenders certified as adults with juvenile offenders not certified," Kristine Kinder, MSA, et al., *Juvenile and Family Court Journal*, 37-42, 1995. For reprints, write to Ms. Kinder at the Department of Criminal Justice, Southeast Missouri State University, Cape Girardeau, MO 63701.

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PARENT-CHILD

Postpartum depression may leave lasting imprint on infants

Babies born to mothers who suffer from major depression are at increased risk for infant psychological disorders, say experts, suggesting that women on antidepressant medication remain in treatment — with some exceptions — during pregnancy.

Several epidemiologic examples have shown that children of parents with major depressive disorder have higher rates of depression in childhood.

While genetics likely plays a role, studies have demonstrated that personal interaction between parent and child has a big impact on the child's psychological well-being.

"Maternal depression is a common postpartum problem that has been shown to compromise infant socioemotional functioning," said M. Katherine Weinberg, PhD, of Children's Hospital in Boston and an instructor in pediatrics at Harvard Medical School.

But researchers didn't realize until recently that even very young children are sensitive to their parents' affect, said Joan Luby, MD, an assistant professor of psychiatry at the Washington University School of Medicine in St. Louis.

Luby said it stands to reason that depressed mothers aren't fully equipped for the demands of parenting a new baby, especially since depression is associated with emotional detachment — at a time when mother-child bonds are being formed.

Weinberg and Luby were among a group of experts who discussed the relationship between maternal depression and infant development last month at the annual meeting of the American Academy of Child and Adolescent Psychiatry in New Orleans.

Babies at very young ages learn to adapt to their parents' depressive behavior. One study showed that babies of depressed mothers protest less in test situations when mothers refuse to play with them than do children of healthy mothers. Luby said the baby has already learned, at only a few months old, that his or her mother isn't always going to be there.

Showing compelling photographs of parent-infant interactions, Edward Tronick, PhD, associate professor of pediatrics at Harvard, illustrated how a depressed, inattentive mother can have profound effects on her infant simply by failing to respond to the infant's need for communication.

The impact may be harder on boys than on girls. Baby girls seem to self-modulate by focusing on objects, such as playing with their hair,

Dad often gets left out of discussions of parent-infant interactions. Fathers often take over for depressed mothers, says Justin Call, MD, emeritus professor of pediatrics and psychiatry at the University of California at Irvine. Call says fathers handle things fairly well — until the mother suffers a serious depressive episode and has to be hospitalized. At this point, the father is at high risk for serious psychological collapse, he says.

Depression considered greater risk than prenatal antidepressant treatment

Given the high risk of depressive relapse — the chance of a second episode is 50 percent; the chance of a third, 70 percent; and a fourth is practically guaranteed — depressed women are more often being advised to remain on medication while pregnant.

"Pregnancy is no longer thought to be protective against depression," says Lynn Grush, MD, a psychopharmacologist at Harvard Medical School.

It can take several weeks for antidepressants to reach therapeutic levels in the bloodstream. For this reason, psychiatrists are beginning to keep pregnant women in psychotropic treatment rather than risk depression during the crucial first weeks of a newborn's development.

Grush advises that women consult their physicians before conception, since the first trimester is the most serious period for drug-related birth defects.

The literature on prenatal exposure to antidepressants is still scant. But studies so far have shown no increased risk of birth defects among babies exposed to the tricyclic antidepressant imipramine. However, a few reports have identified withdrawal symptoms in infants whose mothers took the tricyclic clomipramine (Anafranil) during pregnancy.

Nor does the selective serotonin reuptake inhibitor fluoxetine (Prozac) seem to increase developmental problems in children.

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said Weinberg, of Boston's Children's Hospital.

Boys, on the other hand, cry more, are fussier and become angrier than girls when they find that their mothers aren't paying attention.

Apparently, it's a dynamic interaction. Depressed mothers tend to treat their sons differently, Weinberg said. She detailed a study in which mothers diagnosed with depression were videotaped interacting with their babies — 12 girls and 10 boys — at 3 months and 6 months of age.

The facial expressions of the mothers and children were coded second by second. The results? "At both ages, depressed mothers were more affectively negative with their sons than their daughters," Weinberg said. "They expressed more anger and sadness and less joy with their sons than daughters."

Boys reacted negatively to their depressed mothers, Weinberg reported. "At 3 months, boys expressed less joy and more withdrawal than girls," she said. "At 6 months, they avoided looking at the mother, expressed less joy and self-comforted less than girls."

The findings have disturbing implications. "These data suggest that male infants are more vulnerable to maternal depression and that that vulnerability persists over time," Weinberg said.

Harvard's Tronick showed dramatic pictures from his videotaped sessions of mothers and infants interacting. In one session where mothers were told to put on a still face and not respond to their babies in two-minute sessions, a series of photos showed a child gesture toward his non-responding mother, reach for her, drop his head and finally turn away with a sad expression. ■

— Reported by Ed Susman

Commentary

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learned behaviors that accrue through experience, but that the learned execution of these behaviors is preceded by a period of disorganization and confusion when, as McGraw put it, "the baby doesn't know whether he is a reflexive creature or a learned organism."

Babies are essentially "immune" from SIDS for the first 2 months of life, when inborn reflexes, including the respiratory occlusion response, control most of the baby's behavior, even the response of averting respiratory occlusion or oxygen lack. It is when those reflexes wane that the period of jeopardy begins.

Recently, pediatricians have urged that infants, as a deterrent to crib death, be put on their backs or sides, based on studies showing that crib death occurs more in prone-sleeping babies. One explanation is that babies may re-breathe their spent respiratory products when prone, and die from an overabundance of carbon dioxide, or that babies lying prone, if deficient in their limb and head responses when respiratorily occluded, may be especially vulnerable to re-breathed air poisoning. Before 2 months, the reflexes may be sufficient to deal with the threat, but after the torch is passed to cortical functioning, sufficient learning may not yet have occurred, enabling the baby to self-regulate its respiratory well-being. A critical factor here may thus be a behavioral insufficiency. Time and research will tell.

Keep Your Eye On

... fetal monitoring.

Although electronic fetal monitoring (EFM) is used in nearly three out of four pregnancies in the United States, little significant benefit can be found to justify the routine use of the procedure, according to a large review study in the October issue of *Obstetrics and Gynecology*. The study found that although EFM reduced neonatal seizures, there was also a somewhat higher rate of cesarean deliveries with the use of EFM.

... prenatal testing.

A Columbia University team is developing bioengineering methods of providing safer and more cost-effective prenatal diagnosis. Researchers from both the School of Engineering and Applied Science and the College of Physicians and Surgeons are working together to learn how to recover fetal cells from the blood of expectant mothers. If successful, such a method would eliminate the need for amniocentesis and chorionic villus sampling, two costly and somewhat risky procedures that are now used to determine the health and sex of developing fetuses. Fetal cells are extremely rare in maternal blood, occurring at a rate of only one in 70,000 cells.

... the television?

Adults can learn a lot by watching children watch television. According to physicians at the New York Hospital-Cornell Medical Center, children's television viewing habits may be helpful indicators of vision and hearing difficulties. "One of the first signs of possible vision problems is if your child squints while looking at the television," says ophthalmologist Calvin Roberts. Children may also complain that they cannot read the print on the television, which may signal nearsightedness. If children have astigmatisms, they might confuse the numbers 3 and 8 and 4 and 5.

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COMMENTARY

The enigma of crib death

By Lewis P. Lipsitt, PhD, Editor

Sudden infant death continues as one of the most profound and saddest of biomedical mysteries. The phenomenon of crib death is now regarded as a "syndrome," but its cause remains ambiguous. Sudden infant death syndrome (SIDS) takes the lives of 6,000 to 9,000 babies each year in the United States alone. Estimates vary because diagnosis standards vary regionally and among medical examiners, and because knowledge is still in flux. For example, recent evidence verifies that a few cases previously diagnosed as SIDS were in fact murders. It is impossible to accurately postdict what proportion of baby deaths were really infanticides. One presumes rather few, but this and other vagaries of reportage contribute to epidemiologic error.

SIDS occurs principally between 2 and 5 months, more often among boys than girls, disproportionately in minorities and children of poverty, and is related to various perinatal hazards like hypoxia and maternal drugs and inadequate prenatal care, which predict other adverse developmental outcomes as well. The epidemiology and demographics of SIDS are strikingly similar to those of learning disabilities in surviving children who later manifest developmental delays and other disorders.

There is something special about the period between 2 and 5 months. That is a critical period for dendrite proliferation and myelinization of neural tissue. This is the period in which a significant shift occurs from largely subcortical, reflexive control of behavior to largely cortical mediation of behavior. This is a time of expedited acquisition of learned behavior, a time when people take pleasure in the new social responses of the infant.

From information currently available, it seems that crib death babies appear normal but begin life in some jeopardy, perhaps due to some neuro-reflexive insufficiency; then, a portion of these risky infants succumb due to additional compromising environmental conditions. Data collected at Brown University in the 1970s by Rebecca Anderson and Judy Rosenblith suggested that newborns who do not manifest a vigorous reaction to compromised breathing are at increased risk for SIDS.

Anthropologist James McKenna supports the assumption that there may be behavioral factors involved in infant death even in the absence of any obvious physiological or medical condition. He finds that babies sleeping in the same room as the parents are much less likely to succumb. This suggests that incipient crib death youngsters may make struggling sounds which, if heard and attended to, reduce the likelihood of death. A further possibility, according to McKenna, is that parental breathing sounds may "arouse" the baby who is prone to short periods of breathing shutdown, helping to "jump start" the infant's respiration.

Our article by J.A. Corbyn in this issue provides a possible mechanism for this special jeopardy of babies in the critical first months. The explanation is compatible with the observations of Myrtle McGraw in the 1930s that babies' reflexes eventually yield to adaptive

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Vol. 11, No. 12 December 1995

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How to cope with grief after your adolescent patient commits suicide

Massage improves disorders

By Tiffany Field, PhD

Massage has a long history in treating disorders ranging from mental illness to lumbago. While researching whether massage helps improve the outcomes of sick children, we discovered that the act of giving a massage helps parents too.

Treatment

We train parents to be the massage therapists so their children can be massaged daily at no cost, and to help parents feel less helpless and more involved in the child's treatment. Typically, parents' involvement in their children's treatment involves giving shots or monitoring dietary compliance, as in the case of diabetic children. Being able to be involved in a more positive treatment, such as massage therapy, may be more helpful to these parents.

Some of our studies have been recently completed, and others are ongoing.

Asthmatic children

In one of our studies, mothers gave asthmatic children 20-minute massages every evening at bedtime for a month. According to data analyses, both the mothers' and children's anxiety decreased. In addition, the children's mood improved, and their levels of the stress hormone cortisol decreased.

Most importantly, over the one-month period, they had fewer asthma attacks, and they were able to breathe

(turn to 2)

Genes forecast sex-linked behavior

By Edward Susman

The validity of sexual stereotypes strikes a raw nerve on both sides of the nature vs. nurture debate. Does the happenstance of chromosomes define masculinity and femininity, or is it the family and cultural expectations we're raised with?

Gender

Here's one way to find out: Raise a boy as a girl and see what happens. But although a Johns Hopkins researcher had the chance to observe exactly that, his study offers more questions than answers.

William Reiner, MD, is studying children born with cloacal exstrophy, a rare condition that causes major lower trunk abnormalities. Because the condition severely deforms genitalia, parents often are advised by doctors to have their sons castrated; have female genitalia constructed surgically; and raise them as girls.

Even though they are not told that they were born boys, male traits dominate as the children grow up, says Reiner, of the department of psychiatry and behavioral sciences at Johns Hopkins Hospital.

"One child would never wear dresses," he says. "His parents insisted that the child at least wear a dress to church. On the way home

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PS 025074

This month's client handout: You can recover from an eating disorder

Massage

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better based on daily peak air flow readings.

Autistic children

In this study, we wanted to determine whether massage therapy improved the classroom behavior of preschool autistic children. After one month of massage therapy, the autistic children were less touch sensitive, less distracted by sounds and more attentive in class. They also received better scores on the Autism Behavior Checklist (sensory, relating and total scale scores) and the Early Social Communications Scales (joint attention, behavior regulation, social and initiating behaviors).

Diabetes

Parents' involvement in diabetes treatment is often negative. They have to monitor their children's diets and give painful insulin shots and blood tests. The purpose of this study was to give parents a more positive role in their children's treatment by massaging their children before bedtime.

A preliminary analysis of pilot data on a sample of 13 children showed that, immediately after the massage therapy sessions, both the parents' and the children's anxiety and depressed mood levels had abated. At the end of the one-month period, the parents' insulin and food regulation scores improved, and the children's blood glucose levels decreased to the normal range.

Posttraumatic stress disorder

This study was conducted with children who were traumatized by Florida's Hurricane Andrew and were displaying classroom behavior problems attributable to posttraumatic stress disorder (PTSD). The children were massaged at their school two times weekly for one month. The control group children watched relaxing videotapes during their sessions. After a month, the massaged children had less depression and anxiety and lower cortisol levels. Interestingly, their drawings had fewer depressive and disorganized features. ■

Tiffany Field directs the Touch Research Institute at the University of Miami. For more information, write to her at the University of Miami School of Medicine, Department of Pediatrics, PO Box 016820 (D-820). 1601 NW 12th Ave., Miami, FL 33101.

RESOURCES

Focusing on early 'teens

Search Institute has acquired the resources and services of the Center for Early Adolescence, which closed last summer after 17 years at the University of North Carolina at Chapel Hill. Most of the center's 11,000 publications on middle school reform, youth literacy, parent education and programs for 10- to 15-year-olds are now available from the Search Institute. The institute is also planning to offer training programs for parents and professionals. A newly designed information service is in the works, and is expected to be available in mid-1996. **Contact:** Search Institute, Thresher Square West, 700 S. Third St., Suite 210, Minneapolis, MN 55414; (612) 376-8955.

Therapeutic massage is nothing new

The Ayur-Veda, the earliest known medical text from India (around 1800 BC) lists massage, along with diet and exercise, as primary healing practices.

Throughout history, massage has been variously used for many conditions such as dropsy, mental illness, stomach pain, heart disease, labor pain, infertility, dysmenorrhea, stimulating breast milk, post-surgical healing, disorders of the joints, strained or fractured limbs and rheumatic diseases.

The exotic uses of massage in different cultures have been noted by Jules Older. In New Zealand, he says, the pre-European Maori mothers massage their children's noses to improve their shape, and they massage their legs to lengthen and straighten them.

In Cuba, a garlic and oil massage is prepared and applied to the stomach following "a meal lodged in the stomach where it caused pain and fever." In Samoa, massage is used for every disorder from migraine to diarrhea. There, they use a mixture of coconut milk, flowers from trees and plants, and roots of grasses.

Of the massage therapies, Swedish massage is the most popularly used. Swedish massage is generally divided into six types in order of increasing pressure applied:

1. Effleurage, or stroking
2. Friction: Movement of the hands over the body with more force than effleurage
3. Pressure without movement
4. Petrissage, or kneading: Hands remain stationary, but the fingers move, working their way into sore muscles.
5. Vibration: Typically a machine, as opposed to human touch, is used.
6. Percussion: Slapping, pounding and tapping.

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ETIOLOGY

Researchers find link between tic disorders and strep virus

By Edward Susman

Antibiotic medications may be able to halt the progression of neurological childhood disorders such as Tourette's syndrome and obsessive-compulsive disorder (OCD) if a link between these disorders and the virus that causes strep throat is confirmed.

"As many as one-third to one-fourth of people with childhood onset of obsessive-compulsive disorder and tic disorders may have their condition mediated through infection," says Susan Swedo, MD, acting scientific director and head of the section on behavioral pediatrics at the National Institute of Mental Health (NIMH).

About 250,000 people in the United States have Tourette's syndrome, characterized by multiple motor and vocal tics. And as many as 2 million are believed to have OCD, whose symptoms include recurrent intrusive thoughts and impulses and repetitive behaviors, such as constant hand washing.

Swedo and her colleagues, who have been working on the theory of infection-triggered neurological syndromes for more than a decade, are recruiting patients for studies to try to prove that these disorders are caused by infections and can be treated by modulating the body's immune system, and prevented or at least contained with penicillin.

"Although their finding represents a narrow type of OCD disorders, it is important to recognize that these are very real diseases, caused by a complicated interaction between biological and environmental factors," says Beneath Leventhal, MD, chief of child and adolescent psychiatry at the University of Chicago.

Swedo is enrolling children in several studies as offshoots of the work, honored as the most important report of the year by the American Academy of Child and Adolescent Psychiatry.

An ongoing study compares the effects of intravenous immunoglobulin (IvIg) and plasmapheresis to combat a suspected autoimmune reaction as the culprit in the disorder.

Plasmapheresis, which involves removing whole blood, separating out the plasma and reinfusing the blood suspended in a plasma substitute, removes 95 percent of circulating antibodies. IvIg, through an unknown mechanism, either removes or blocks effects of the antibodies.

To date, nine children, whose average age is 12, have been randomized to receive plasmapheresis, IvIg or sham IvIg.

Two children with sham IvIg showed no response, but three who received IvIg showed a 30 percent reduction in OCD symptoms and a 42 percent decrease in movement disorders when they were measured two to four weeks after cessation of therapy. Plasmapheresis resulted in a 52 percent reduction in OCD symptoms and an almost 75 percent reduction in movements.

The average length of remission was 42 weeks.

"These treatments are very dramatic, are clinically quite significant and are also long-lasting," Swedo says. "We need to prove definitively that these immunomodulatory treatments are effective, as well as to extend our sample so we can better describe what this syndrome looks like."

Another study will try to determine if penicillin can prevent episodes of the disorders. This study will eventually enroll 75 children, but preliminary results show a positive effect.

"There should be a role for penicillin in this disorder," Swedo says. "We speculated, if our model is correct, penicillin prophylaxis for these children might be able to prevent the exacerbation of their disease."

If PANDAS (Pediatric Autoimmune-Mediated Neuropsychiatric Disorders Associated with Streptococcus) is related to strep antibodies, Swedo theorizes, then preventing those antibodies from being formed should prevent symptoms from progressing.

Criteria for a diagnosis of PANDAS

- Lifetime diagnostic criteria for OCD or tic disorder.
- Pediatric onset prior to puberty.
- A clinical course described as either an abrupt onset or dramatic exacerbation of symptoms.
- An association with strep infections, confirmed by a positive throat culture.
- Neurologic abnormalities, most often choreiform movements, and sometimes motor tics.

Swedo cautioned doctors to avoid putting children on penicillin until the study results are confirmed. "We haven't yet proved that penicillin works for this disorder," she says, adding, "We are very excited."

Swedo's curiosity in the strep virus was piqued by a 10-year-old boy whose hoarding behavior was so severe he couldn't walk through the doctor's waiting room because he had to pick up every piece of paper he could see. He also had spitting rituals and carried plastic cups to hoard his expectorate.

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"The interesting thing was that his symptoms had begun overnight," Swedo says. "His mother described how the symptoms came out of the blue, very dramatically, very severely."

The boy's mother, who kept detailed medical histories of her children, said that when her son had had previous strep infections, he developed motor tics a while later. His severe OCD came three weeks after strep throat.

"She insisted that there had to be a connection, and we believed she was right and it was that that led to the study," Swedo says.

She also looked to the 17th-century work of Thomas Sydenham and Sir William Osler, who described children afflicted with disorders that seem close to present-day OCD and Tourette's syndrome. Sydenham's chorea is characterized by involuntary, jerky movements and is the neurological variant of rheumatic fever, which is strongly associated with strep A infection.

The NIMH researchers made what Swedo calls "a leap of faith" and determined that the bouts of OCD seen in Sydenham's chorea were the same as occurred in childhood-onset OCD.

Swedo said researchers still don't know why one child will contract strep and have no ill effects, while others will come down with myriad symptoms, including rheumatic fever, Sydenham's chorea, OCD and tic disorders.

She is leaning toward the idea that a child is genetically predisposed to Tourette's or OCD. There is a genetic component to both OCD, which is also linked to Tourette's syndrome, and rheumatic fever.

"It has been known for decades that there are rheumatogenic families," Swedo says. "If three families lived in the same house and were exposed to the same strep, one family would have a child that would have rheumatic fever and the other two families would be spared."

The families of children with Sydenham's chorea have a greater family history of rheumatic fever; the children with chronic OCD have markedly increased rates of OCD and tic disorders in their first-degree relatives.

"The children with PANDAS fall exactly in between them; they have increased rates of OCD and tic disorders, and they also have increased rates of Sydenham's chorea and rheumatic fever," Swedo says.

"One possible explanation is that this is a dual genetic hit, that these kids have been unlucky enough to receive the gene for rheumatic fever susceptibility as well as the gene or genes for OCD/Tourette's."

Susan Swedo is looking for subjects for her studies. If you have a patient who might meet the criteria, call the NIMH office at (301) 496-5323. Edward Susman is a freelance writer specializing in health.

Speaking of Books

Eating Disorders and Obesity: A Comprehensive Handbook
Kelly D. Brownell &
Christopher G. Fairburn, Eds.
Guilford, New York
583 pages, $55

This is the current "bible" or encyclopedia on eating aberrations and their consequences, with 101 sections authored by most of the major researchers in the field.

Overcoming Binge Eating: A New Scientifically Based Program
Christopher G. Fairburn
Guilford, New York
246 pages, $32.95 (hardcover), $14.95 (paper)

This book provides excellent information with which to understand and control binge eating and describes a self-help program based on proven strategies.

Social Work in Pediatrics
Ruth B. Smith &
Helen G. Clinton, Eds.
Haworth, Binghamton, NY
136 pages, $19.96

This excellent compilation of previously published articles addresses such topics as respite care for HIV-affected families, social work in pediatric oncology, home care for children dependent on technology, and stress and coping during a child's hospitalization.

Protecting Children from Abuse and Neglect: Foundations for a New National Strategy
Gary B. Melton &
Frank D. Barry, Eds.
Guilford, New York
451 pages, $40

At least 3 million reports of maltreatment occur nationally. An exceptional resource for mental health professionals, child rights advocates and policymakers, the book advances a comprehensive neighborhood-based, child-centered, family-focused child protection system.

True and False Allegations of Child Sexual Abuse: Assessment and Case Management
Tara Ney, Ed.
Brunner/Mazel, New York
371 pages, $45.95

Major issues relating to testimony and treatment, with some of the major writers in the field like Peter Ornstein, Elizabeth Loftus and Michael Yapko. Topics include the language of the child abuse interview, the child witness in sex abuse cases, psychotherapy and recovery of repressed memories, and family considerations.

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Get the help you need to recover from an eating disorder

When Karen wasn't chosen for the lead in the school play, she believed that it was because she was too fat. At 5'3" and only 110 pounds, she began a crash diet, skipping lunch entirely. She decided she wasn't losing weight quickly enough, so she skipped breakfast as well, until her daily consumption was only 300 calories!

After weeks of literally starving herself, Karen fainted while boarding the school bus. She was rushed to the emergency room; she weighed 90 pounds. The physician saw how emaciated she was and admitted her immediately. Karen suffered from anorexia nervosa.

Laurie, a high school senior, loved to go to parties with her friends. Unlike her friends, however, Laurie would eat several slices of pizza, big slabs of cake, and handfuls of chips and cookies. Her friends were always amazed that she could eat that way and not gain weight. What they didn't know was that after eating, Laurie would slip into the bathroom and make herself throw up.

After several months of bingeing and self-induced vomiting, Laurie developed a serious ulcer. Her doctor diagnosed her with bulimia nervosa.

Karen and Laurie both suffer from eating disorders — complex psychological illnesses in which victims become obsessed with food and their body weight. People who have eating disorders have extremely distorted body images; they feel that they're fat, despite even life threatening emaciation. Without treatment of both the emotional and physical symptoms of these illnesses, victims can suffer malnutrition, heart problems, and other potentially fatal conditions.

Eating disorders affect more than half a million people in the United States, 90 to 95 percent of whom are young women and girls. Anorexia nervosa usually is characterized by a refusal to maintain a minimally normal body weight. Bulimia nervosa is defined as periods of binge eating, followed by purging, through means of self-induced vomiting, or abusing laxatives or diuretics.

Some researchers believe that people suffering from eating disorders are trying to gain some measure of control over aspects of their lives. Eating disorders are a response to the environment, a means of exerting control, or coping with stress or tension.

Other theorists blame societal norms that emphasize an unattainable physical ideal. The emotions that young women experience as a result of failing to meet this unreasonable standard — guilt, anxiety, fear — can cause them to begin the cycles of dieting and denial, or bingeing and purging.

Research suggests that there are bio chemical components of eating disorders as well. This would help to explain why many people with eating disorders also suffer from depression. Imbalances in certain brain chemicals called neurotransmitters, which control appetite, mood, and sleeping, may cause the eating disordered behaviors.

Eating disorders clearly illustrate the relationship between emotional and physical health. The psychological disorders of anorexia and bulimia directly affect physical health, leading to physical problems that in turn, worsen the patient's emotional problems.

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Because treatment for eating disorders must address both components — the physical and the psychological — most patients benefit from a combination of medication and psychotherapy. The talk therapy helps patients to understand the emotions that trigger eating disorders, and to correct distorted self-images.

Psychiatrists typically prescribe antidepressants for eating disorder patients. As a group, antidepressants work by interacting with the chemicals in the brain. The antidepressants alleviate some of the symptoms of depression that typically accompany eating disorders, allowing the talk therapy component of treatment to be more effective.

Eating disorders are complex illnesses that often require intensive treatment. However, people who suffer from eating disorders have a good chance for complete recovery, especially if their illness is recognized early.

For more information, contact any of the following organizations:

American Anorexia/Bulimia Association, Inc.
418 E. 76th Street
New York, NY 10021
(212) 734-1114

Center for the Study of Anorexia and Bulimia
1 W. 91st Street
New York, NY 10024

National Anorexic Aid Society, Inc.
P.O. Box 29461
Columbus, OH 43229

National Association of Anorexia Nervosa and Associated Disorders
P.O. Box 7
Highland Park, IL 60035
(312) 831-3438

National Institute of Mental Health
Eating Disorders Program
Building 10, Room 35231
Bethesda, MD 20892
(301) 496-1891

Source: "Let's Talk Facts about Eating Disorders," a publication of the American Psychiatric Association, 1400 K St., NW, Washington, DC 20005.

The Brown University Child and Adolescent Behavior Letter

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Prepared by Mary-Kim Arnold, editorial assistant.

Does sugar aggravate attention-deficit disorder?

A new study seems to support the side that says simple sugars worsen the symptoms of children with attention-deficit disorder (ADD). Previous research has offered conflicting results. In the current study, researchers measured the metabolic, hormonal and cognitive responses of 17 children with ADD and 11 control group children, at baseline and three to five hours after ingesting a standard dose of glucose (1.75 g/kg). Both groups had identical glucose and insulin levels. But plasma epinephrine and norepinephrine levels, while similar between groups at baseline, diverged after oral glucose was administered. The rise in epinephrine was significantly greater in the control group, and norepinephrine levels fell in children with ADD but not in controls. On a matching test designed to measure attention, children with ADD responded more quickly but less accurately than control children at baseline and throughout the study. The researchers said that the lower norepinephrine levels are consistent with reduced central sympathetic activity, which has been suggested in other studies of children with ADD. Until these findings are confirmed, the researchers recommend prudent intake of simple sugars.

Nancy L. Ginardi, et al., "Blunted catecholamine responses after glucose ingestion in children with attention deficit disorder," *Pediatric Research*, 38(4):539-542, 1995. For reprints, write to William V. Tamborlane, MD, Department of Pediatrics, Yale School of Medicine, 333 Cedar St., New Haven, CT 06510.

Teens' psychiatric problems persist into adulthood

Adolescence is a period of intense life changes, and many would not be surprised if a teenager were to show signs of anxiety or depression. But should it be considered normal? Two researchers say no. To assess psychiatric symptoms in adolescents, they interviewed the parents of 13- to 16-year-olds. Eight years later, the now young adults were given a similar questionnaire to ascertain whether the symptoms reported by their parents had persisted. The authors found that adolescent problems tended to persist into young adulthood, manifesting as specific psychiatric disorders or maladjustment. A minority of subjects who endorsed psychiatric symptoms in adolescence were improved eight years later, and a very small percentage who were well reported substantial symptoms at follow-up.

"Psychopathology from adolescence into young adulthood: an 8-year follow-up study," Robert F. Ferdinand and Frank C. Verhulst, *American Journal of Psychiatry*, 152(11):1586-1594, 1995. For reprints, write to Dr. Verhulst, Department of Child and Adolescent Psychiatry, Sophia Children's Hospital/Erasmus University, Dr. Molewaterplein 60, 3015 GJ Rotterdam, The Netherlands.

Effects of abuse worsened by maternal depression

Intervention strategies for abused children should take into account the extent of depressive symptoms in the children's mothers, according to a new study. The study compared mother and teacher ratings of behavior problems in 172 elementary school-aged abused children and a control group of 155 children who had not been abused. Mothers and teachers rated abused children, both boys and girls, as having greater behavioral problems than non-abused children, with abused boys having more problems than abused girls. Regardless of abuse status, mothers and teachers did not significantly differ in their ratings, as scored on the Achenbach Child Behavior Checklist. The combination of abuse and maternal depressed mood resulted in the greatest problems for children. Both raters reported greater problems in the clinical range for abused boys than for non-abused boys, but few differences were noted between abused and non-abused girls.

E. Milling Kinard, "Mother and teacher assessments of behavior problems in abused children," *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(8):1043-1053, 1995. For reprints, write to Dr. Kinard, Family Research Laboratory, 126 Horton Social Science Center, University of New Hampshire, Durham, NH 03824.

Stress hormones reduced in breastfeeding mothers

Women who breastfeed their infants produce lower levels of stress response hormones than do women who bottle-feed, according to research conducted by the National Institute of Mental Health (NIMH). The researchers theorize that lactation-induced suppression of stress responses may minimize the psychological stress associated with the demands of infant care. They studied 20 postpartum women, 10 who were lactating and 10 who were not. Before exercising on a treadmill — the same type of "stress test" given to cardiac patients — levels of the stress response hormones adrenocorticotropic hormone (ACTH), cortisol and vasopressin were similar in both the lactating and non-lactating groups. In response to the stress of exercise, all participants showed an increase in hormone levels; however, the increase was significantly less among women who were breastfeeding their babies compared to those who were bottle-feeding. Lactating women had lower levels of ACTH and cortisol and showed a trend toward a lower vasopressin response than did non-lactating women.

"Suppression of hypothalamic-pituitary-adrenal axis responses to stress in lactating women," Margaret Altemus, et al., *Journal of Clinical Endocrinology and Metabolism*, 80(10):2954-2959, 1995. For reprints write to Dr. Altemus, Laboratory of Clinical Science, Building 10, Room 3D41, 10 Center Drive MSC 1264, Bethesda, MD 20892-1264.

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Keep Your Eye On

... teen pregnancy.

The national birth rate for 15- to 19-year-olds decreased by 2 percent in 1992, following a 24 percent increase from 1986 through 1991, according to a recent analysis by the Centers for Disease Control and Prevention (CDC). But pregnancy and birth rates did not decrease equally for all groups of teenagers. For example, pregnancy rates for those below 15 years old decreased significantly in only one state. In addition, percentage decreases in pregnancy rates for 15- to 19-year-olds were greater for whites than for blacks; consequently both pregnancy and birth rates remained higher for blacks than whites. Birth rates remained higher for Hispanics than for non-Hispanics.

... what they say about sex.

Sex, etc., "a newsletter by students for students," has, in its third year, an impressive circulation of 100,000 New Jersey teenagers. *Sex, etc.* is produced by an editorial board of high school students, who are assisted by an adult journalist and health professionals. The newsletter is read — and sometimes used to supplement family life education and health texts — in 75 percent of New Jersey high schools. The editorial content focuses on the availability of assistance for those engaged in risky behaviors; reasons for abstaining from or postponing sexual activity; means of reducing risks of HIV/AIDS, other STDs and unwanted pregnancy; dangers of drug, alcohol and cigarette use; means of controlling violence; and the values of diversity and tolerance. (Network for Family Life Education, Rutgers, The State University, Building 4086, Livingston Campus, New Brunswick, NJ 08903, (908) 445-7929)

... water balloons.

Water balloon slingshots — advertised as toys — can knock a person unconscious at 900 feet, result in cataract-causing injuries in children, and can fracture bones. Studies by John Bullock, MD, chairman of ophthalmology at Wright State University in Dayton, OH, show that these slingshots can produce energy similar to that of bullets. Bullock says parents and government regulatory agencies should realize the slingshots are not toys.

... lazy eye.

Levodopa, a medication used to treat Parkinson's disease in adults, has been shown to be effective in older children who have failed other therapies for amblyopia, a dullness of vision without a detectable cause, known familiarly as "lazy eye." These children and teenagers, generally considered too old for eye patch techniques, improved after a seven-week levodopa regimen, according to Lawrence Leguire, PhD, director of electrophysiological testing and eye research at Children's Hospital in Columbus, OH.

... the whole family.

Involving families in the psychotherapeutic treatment of a wide range of disorders, including those affecting children and adolescents, significantly improves outcomes, according to a review of studies published in a special issue of the *Journal of Marital and Family Therapy*. The research shows that marriage and family therapy effectively treats adolescent drug abuse and anorexia in young adult women. For children, MFT seems to work for autism, conduct disorders, chronic physical illness and aggression and non-compliance in attention-deficit hyperactivity disorder.

... children of immigrants.

The number of children of immigrants will rise to 9 million in 2010, representing 22 percent of the school-age population, but research on these children and their families is scarce. A recent workshop convened by the Board on Children and Families of the National Research Council calls for more research on the adaptation of immigrant children to life in the United States. Unanswered questions include: Why do some of these children succeed in school and others fail? How do the economic or political factors motivating parents' immigration, and their status as legal or illegal immigrants, affect the development of children? (*The Future of Children*, summer/fall 1995, Center for the Future of Children, David and Lucile Packard Foundation, 300 Second St., Suite 102, Los Altos, CA 94022; (415) 948-3696)

... the youngest victims of war.

The small ethnic conflicts and violent skirmishes that characterize modern warfare have taken their toll on children, according to a report issued this month by UNICEF. In the last decade, 2 million children were killed in wars that have been statistically more devastating to civilians than to soldiers, according to the report. Additionally, 4 million to 5 million children have been disabled; 12 million are homeless; and more than a million orphaned or unable to locate their parents. ("State of the World's Children 1996," U.S. Committee for UNICEF, 333 E. 38th St., 6th Floor, New York, NY 10016)

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Sexual stereotypes

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from church, the child would take off the dress in the car."

Of the study's six XY children being raised female, five hate wearing dresses, Reiner says. The sixth reportedly likes dresses, according to the child's mother.

"The implications of this study," Reiner says, "may be that some of the things we associate with being a boy or a girl are due to the fact that is more natural for girls to wear dresses or play house."

Does that mean we're hard-wired for stereotypical sex traits? "This study suggests most likely we are born with a genetic program," says Robert Findling, MD, an assistant professor of psychiatry and pediatrics at Case Western Reserve University. "Environment plays a part in how we develop, but probably a lot of what we are is there at birth."

Four of the children in Reiner's study dislike playing house; in general, they don't want to get married and aren't interested in having babies. The six also preferred high-contact, high-action sports such as baseball, football and basketball.

All the XY children scored high in "tomboyishness," the researcher says. "Normal girls may go through a period in which they exhibit tomboy qualities, but rarely are those periods so long-lasting or extreme as the ones exhibited by these children."

Cloacal exstrophy occurs in one in 350,000 live births a year — about six cases a year in the United States. Reiner says the children in his study, now 10 to 12 years old, are uniformly bright, but their physical development is stunted, and most are wheelchair-bound. Other sequelae include pelvic malformations, short bowel syndrome and often spina bifida.

The children are carefully protected by their parents, who have hidden the secret of their births.

One, however, pieced together the clues. "He went to the library and read everything he could find about male sexuality and realized he fit the criteria," Reiner says. He confronted his mother, who admitted he was born a boy. The child was so angry that he went to court and had his name changed.

When the children are about 15 years old, they have to take hormones to develop female characteristics, such as breasts. Eventually they will have to be told the truth about their birth, Reiner says, "and I think they will have a lot of trouble with that psychologically."

He says that changing the sex of these children may not be in their best interests.

Reiner's study will eventually enroll 28 children, including girls born with the same condition who are raised as girls. "They seem to have the same expectations as one would expect from girls," he says. ■

Edward Susman is a freelance writer specializing in health.

How to get girls into math and science

A new report by the American Association of University Women (AAUW) Educational Foundation documents how classrooms and communities around the country have used innovative teaching techniques, strategies and basic principles to raise girls' interest and achievement in math, science and technology — areas traditionally dominated by boys.

Growing Smart: What's Working for Girls in School cites cooperative learning, single-sex classes, greater hands-on access to computers and tools, the pairing of teachers and classes for consecutive grades and mentoring among the practices shown to shrink the math/science gender gap between girls and boys.

Past AAUW research revealed pervasive gender bias through differential treatment by teachers that steered girls away from math and science, and through competitive learning environments where boys tended to dominate and girls were marginalized. Girls' own perceptions of their academic abilities were found to play a critical role in guiding their course selections and influencing their pursuit of leadership opportunities.

The report recommends that schools:

- ✔ **Reinforce girls individuality** through single-sex classes that boost girls' lagging self-perceptions in areas such as math and science.
- ✔ **Foster girls' involvement** through cooperative learning groups that eliminate competitive classroom practices that often marginalize girls.
- ✔ **Provide girls with mentors and role models** by pairing teachers and classes for consecutive grades and by creating multi-age classrooms that reduce the risk of girls dropping out of math, science and technology courses.
- ✔ **Give girls equal access to learning** though hands-on experience with computers and lab equipment, tools that are often dominated by boys.
- ✔ **Empower girls to achieve goals** by working with community groups and businesses to provide girls with routes to success other than such traditional measures as testing, grades and class participation.

For a copy of the report, send $35.95, plus $4 for shipping and handling, to the AAUW Sales Office, Department 327, PO Box 251, Annapolis Junction, MD 20701-0251, or call 1-800-225-9998, Ext. 327. A summary of the report is available for $12.95, plus $4 shipping and handling.

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COMMENTARY

Pointing fingers

Before the year is over, 2,000 children will have died from confirmed and blatant abuse — five children each day in the United States.

Now our government is cutting social services and protective facilities for children who are at risk for abuse to bare bones support, to be administered by states that are inadequately prepared to handle the disciplinary excesses and assaultive behavior of some parents and other purported "caregivers" of children. Many fatal cases in the past few months warrant closer investigation into the real causes of their deaths, and the inability of the current system to detect and respond to clear signs of abuse.

We must rethink what child abuse is about. It is about blaming children for the problems of adults. Almost invariably, when parents are confronted with their abuse of their children, they cite many adverse life conditions that led them to do what they did. They lost their jobs or their spouse or were jilted by their lover, or their paycheck was stolen, they got sick, the baby cried constantly, or "the kid just wouldn't obey." False accusation is rampant in what they report.

Whenever our economy is in trouble, and the climbing national debt is brought to our attention, we scapegoat the children. Social services for children and youth go out the window. Kids are accused of wrecking the economy with their mischievous and irresponsible behavior. The money goes away for kids who need compassion, job support systems and mentors outside of the home. The children easily become victims of a culture of bullying, meanness, ethnic and racial hatred, and other forms of false accusation. Alas, the escalation of these assaultive behaviors to death at an early age is especially prevalent among minorities and the poor. Make no mistake about it: The insurance company statisticians can tell you that just as youth itself, especially the young male, is an endangering index, so are race and poverty.

We are quick to accuse and punish the children, the adolescents and the minorities for devastating our hopes and dreams. We take away the services needed most by the afflicted and give the have-nots short shrift in our economy, compared with the generous tax and other social incentives offered to those who already have more — as if the needy are those who created our national debt.

How many times do we have to listen to the eloquent words of Cornel West, Elie Wiesel, and Jesse Jackson, or the incomprehensibly tragic news reports from Bosnia, or the stories too often neglected of the Asian holocausts, to understand that *false accusation* is at the root of most evil relationships among humans? Don't we know enough yet, whether by intuition, revelation or behavior science, to realize that the accusatory posture — from childhood in the form of teasing, bullying and peer fighting, to scapegoating and warfare in adults — is a recurring (but changeable) human behavior pattern that destroys other humans? Have we, as scientists and humanists, no shame for not acting on what we already know, on behalf of children, and what we could know so quickly — with a fraction of the funds currently invested in the space program?

Lewis P. Lipsitt

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The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

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